together with EXDENSUR (depemokimab-ulaa)

Together with GSK Enrollment Form

Fax completed enrollment form to 1-844-237-3172
For assistance, please call 1-844-CALL-TwGSK (1-844-225-5894)
Monday – Friday, 8 AM to 8 PM ET

Visit us at www.TogetherwithGSK.com

An electronic enrollment form is available online. Scan the QR code to access Together with GSK.

Program services include:

- Coverage Support
- Patient Assistance Program (PAP)*
- Copay Assistance Program
- Disease State and Product Education
- Claims and Billing Support

*The GSK Patient Assistance Program is operated by the GSK Patient Access Programs Foundation, an independent non-profit organization separate from GSK.

Patient Information

*Indicates required fields

Last name*:		First name*:
Street*:		City*:
State*:	Zip*:	Email*:
Date of birth* (mm/dd/yyyy):	Gender:	Language preference (if other than English):
Preferred phone #*: ☐ Home ☐ Mobile		Alternate contact name:
OK to leave a detailed voicemail? ☐ Yes ☐ No		Alternate contact phone #: ☐ Home ☐ Mobile
Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening		Alternate contact relationship to patient:

Enroll in Mobile Text Notifications (optional):

☐ *Opt-in (include mobile phone number above)*

By providing your phone number and checking this box, you are opting in to receive SMS alerts from Together with GSK-Specialty. These text messages may be generated using auto-dial at the number you submit. Message frequency varies. Text HELP to 45851 for help and STOP to opt out; message and data rates may apply. Refer to the Terms and Conditions and Privacy Notice below or attached to the first text message. Visit https://togetherwithgsk.com/terms-and-conditions/ and https://privacy.gsk.com/en-us/privacy-notice/ for more information.

Print name: | Relationship to patient:

PATIENT TO SIGN — PATIENT SIGNATURE REQUIRED HERE | Date:

I have read and agree to the HIPAA Patient Authorization Form (please see page 4).*

PATIENT TO SIGN — PATIENT SIGNATURE HERE | Date:

I have read and agree to the Marketing Opt-in Consent included on page 3 (optional).

Insurance Information: Please provide front and back copies of all medical and prescription insurance cards.*

☐ No insurance	Primary insurance	Secondary insurance	Pharmacy insurance
Insurance provider:			
Insurance phone:			
Cardholder name (if not the patient):			
Cardholder date of birth:			
Policy #:			
Group #:			
BIN/PCN:	N/A	N/A	

Is a prior authorization on file with the payer? ☐ Yes ☐ No | If "Yes," authorization #: | Expiration date:

Patient Assistance Program† (PAP): Patient is to complete if requesting PAP assistance.

Uninsured and eligible Medicare patients who are prescribed EXDENSUR may be eligible for GSK's PAP.
To find out if you qualify, please fill in the information below.

Annual pre-tax household income:	Number of family members living in the household:
Medicare Beneficiary Identifier (MBI):	

PATIENT TO COMPLETE

Applicants authorize the GSK Specialty PAP and its administrators to obtain a consumer report. The consumer report, and the information derived from public and other sources, will be used to estimate income as part of the process to decide eligibility to receive free medication from the GSK Specialty PAP. Upon request, the GSK Specialty PAP will provide applicants with the name and address of the consumer reporting agency that provides the consumer report. The program may request additional documents and information at any time, even after enrollment, to determine whether the information on the enrollment form is complete and true. Patients who participate in or are enrolled in an Alternate Funding Plan are not eligible for GSK PAP. For additional questions about eligibility, please contact the Together with GSK or GSKPAF.org.

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***Indicates required fields**

Prescriber, Acquisition, and Administration Information: Prescriber signature is required on all enrollment forms.

Prescriber's last name*:	Prescriber's first name*:		
Practice name*:	Specialty:		
Street*:	City*:	State*:	Zip*:
Office contact name*:	HCP communication preference*:	☐ Email	☐ Phone
Email:	Phone*: Ext:	Fax*:	
Prescriber Tax ID*:	State license #*:		
Prescriber NPI #*:			

Preferred Site of Care for Benefit Verification*	Administration Site	Acquisition Method
☐ Prefilled syringe (PFS)	☐ Medical doctor's office (MDO) ☐ Alternate site of care (ASOC)	☐ Buy & bill ☐ Specialty pharmacy

Site of Care: Complete this section ONLY if the place of administration differs from the prescribing office.

Administering practice/facility:	Administering physician name:		
Street:	City:	State:	Zip:
Phone: Ext:	Fax:	NPI:	

☐ Check here if Together with EXDENSUR support is needed to identify an alternate site of care.

*Diagnosis Codes and Clinical Information: It is up to the provider to determine the most appropriate diagnosis code. Consult the patient's payer for coding or documentation requirements.

Severe Asthma	☐	J45.50	Severe persistent asthma, uncomplicated
	☐	J45.51	Severe persistent asthma with (acute) exacerbation
	☐	J82.83	Eosinophilic asthma
Other ICD-10-CM code	☐		

Prescriber, Acquisition, and Administration Information (cont.)

Patient name:	**Date of birth (mm/dd/yyyy):**

• Prescriber signature below is required for Rx and/or enrollment • Specialty pharmacy selection is subject to health plan requirements

☐ New ☐ Restart ☐ Continuing	Last treatment date (mm/dd/yyyy): Next treatment date/Date needed by (mm/dd/yyyy):

Has the prescription already been forwarded to a specialty pharmacy? ☐ No ☐ Yes—which one?

Would you like us to triage the prescription to a specialty pharmacy?
☐ No ☐ Yes— ☐ CareMed Specialty Pharmacy ☐ Walgreens Specialty Pharmacy

Allergies:	Concurrent therapy:

Prescription: Prescriber to indicate preferred dosing regimen of EXDENSUR.

MEDICATION			STRENGTH/FORM	QTY	REFILLS	DIRECTIONS FOR ADMINISTRATION
Office-Administered	EXDENSUR pre-filled syringe (PFS)	☐	**100 mg/mL** solution single-dose pre-filled syringe (NDC 0173-0927-42)			☐ **Severe Asthma:** 100 mg subcutaneous to upper arm, thigh, or abdomen every 6 months

Prescriber Declaration: I certify that the information provided above is true and that EXDENSUR is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out-of-pocket cost for EXDENSUR would be collected from the patient upon treatment. I appoint the Together with GSK program, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. **Special Note:** Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

PRESCRIBER TO SIGN	PRESCRIBER SIGNATURE REQUIRED HERE	
	SUBSTITUTION PERMITTED (Date)	**DISPENSE AS WRITTEN* (Date)**

Marketing Opt-in Consent (Optional)

GSK offers helpful services and resources that help you begin and continue treatment with EXDENSUR. GSK believes your privacy is important. By providing your name, address, email address, and other information including your indication above, you are giving GSK and companies working for or with GSK permission to contact you for marketing, market research, or advertising purposes, or to invite you to interact with GSK in other ways across multiple channels (eg, mail, email, websites, online advertising, applications, and services) regarding the medical condition(s) in which you have expressed an interest, as well as other health-related information from GSK. GSK will not sell or transfer your name, address, or email address to any other party for their own marketing use.

Patient email:

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PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

Visit us at www.TogetherwithGSK.com

By signing this form, **I authorize** my doctors; pharmacies, including my Specialty Pharmacy(ies); alternate site of care; and health insurers (collectively, my "Healthcare Providers") to use and disclose my personal health information (my "Information") to GlaxoSmithKline and to the GSK Patient Access Programs Foundation and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and share my Information for purposes of providing Together with GSK services or Patient Assistance Programs, which may include the following activities:

1) Communicating with my Healthcare Providers about my EXDENSUR prescription and medical condition;
2) Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for GSK's patient assistance and co-pay assistance programs;
3) Contacting my insurer, other potential funding sources, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds;
4) Disclosing my information to third parties if required by law;
5) Sending me educational information about EXDENSUR and contacting me to describe (and, if I am interested, to provide) optional educational services offered by healthcare professionals; and
6) If I sign the Together with GSK Support Consent on page 1 of this form, sending me promotional information as described in the Together with GSK Support Consent paragraph on page 3 of this form.

By signing this authorization, **I acknowledge** my understanding that:

- My Healthcare Providers may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on my signing this Patient Authorization.
- Certain Healthcare Providers, such as Specialty Pharmacies, may receive payment from GSK for disclosing my Information to GSK as permitted by this authorization.
- Once my Information is released to GSK based on this authorization, federal privacy laws may no longer protect the Information from re-disclosure. However, I also understand that GSK intends to share my Information only as described in this authorization or as otherwise permitted by law.
- This authorization will remain in effect for two (2) years after I sign it or for as long as I participate in the **Together with GSK** or the GSK Patient Assistance Program, whichever is longer, subject to any applicable state law requirement for the authorization to expire.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to Together with GSK, 2250 Perimeter Park Drive, Ste. 300, Morrisville, NC 27560. Such a revocation will invalidate reliance on the authorization to use or disclose my Information, but will not invalidate any uses or disclosures made prior to the date my written statement of revocation is received. I understand that, even if I revoke the authorization, GSK may maintain my Information as part of records of my participation in the Together with GSK and GSK Patient Assistance Program.
- I understand that I, as the patient or a legal representative signing on behalf of the patient, have a right to receive a copy of this signed form.

The patient, or the patient's authorized representative, MUST sign this form to receive Together with GSK or GSK Patient Assistance Program services. If an authorized representative signs for the patient, please indicate relationship to the patient.

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