ENROLLMENT FORM

Gateway to Nucala

Please complete the form, sign, and FAX to: 1-844-237-3172

For assistance, please call: 1-844-468-2252
(Monday – Friday, 8AM to 8PM ET)

Scan to access and complete eEnrollment form

Scan to save contact information for Gateway to NUCALA

Gateway to NUCALA Services

- Benefits Verification and Prior Authorization Research
- Prior Authorization Follow-up and Appeal Support
- Co-pay Program **(commercial only)**
- Patient Assistance Program (PAP)
- Specialty Pharmacy (SP) Triage
- Claims and Billing Support
- **MyNUCALA Support (Optional):** Disease-specific education, patient support services, and other communication

***Indicates required fields**

Patient Information

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		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 opting into texting you authorize GSK and its service providers to contact you and send communications about your enrollment in Gateway to NUCALA via telephone and text message. These calls or text messages may be generated using auto-dial or pre-recorded messages at the number you submit. The number and type of messages will be based upon your program selections, and message and data rates may apply. At any time, you may request to stop telephone calls or text messages by following the opt-out directions provided during those communications.

Print name: | Relationship to patient:

GATEWAY PATIENT AUTHORIZATION*

PATIENT SIGNATURE REQUIRED HERE | Date:

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

MYNUCALA SUPPORT CONSENT

PATIENT SIGNATURE HERE | Date:

I have read and agree to the OPTIONAL MyNUCALA Support consent (please see page 3).
If you have chosen to participate in the MyNUCALA Program, please fill in your email on page 3.

*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 DOB			
Policy #			
Group #			
BIN/PCN	N/A	N/A	

Is a Prior Authorization on file with the Payer? ☐ Yes ☐ No | Authorization #: | Expiration Date:

Patient Assistance Program† (PAP): Patient to complete only if requesting PAP

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

Annual pretax household income:	Number of family members living in 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 if the information on the enrollment form is complete and true. Patients who participate or are enrolled in an Alternate Funding Plan are not eligible for GSK PAP. For additional questions about eligibility, please contact the Gateway to NUCALA or GSKforYOU.com.

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

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***Indicates required fields**

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

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

Preferred Formulation for Benefit Verification (choose all that apply)*	**Acquisition Method**	**Administration Site**
☐ Lyophilized Vial (LYO)	☐ Buy & Bill ☐ Specialty Pharmacy	Office administered only
☐ Autoinjector (AI)	Specialty pharmacy	Patient administered
☐ Prefilled Syringe (PFS)	Specialty pharmacy	Patient administered

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

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

☐ Check here if Gateway support is needed to identify an appropriate Site of Care (infusion center)

***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.

Chronic Obstructive Pulmonary Disease (COPD)	☐	J44	Chronic obstructive pulmonary disease		☐	J41	Simple and mucopurulent chronic bronchitis
	☐	J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection		☐	J41.0	Simple chronic bronchitis
	☐	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation		☐	J41.1	Mucopurulent chronic bronchitis
	☐	J44.89	Other specified chronic obstructive pulmonary disease		☐	J41.8	Mixed simple and mucopurulent chronic bronchitis
	☐	J44.9	Chronic obstructive pulmonary disease, unspecified		☐	J42	Unspecified chronic bronchitis
	☐	J40	Bronchitis, not specified as acute or chronic		☐	J43	Emphysema
Severe Asthma	☐	J45.50	Severe persistent asthma, uncomplicated	**Hypereosinophilic Syndrome (HES)**	☐	D72.110	Idiopathic hypereosinophilic syndrome [IHES]
	☐	J45.51	Severe persistent asthma with (acute) exacerbation		☐	D72.111	Lymphocytic variant hypereosinophilic syndrome [LHES]
	☐	J82.83	Eosinophilic asthma		☐	D72.119	Hypereosinophilic syndrome [HES], unspecified
Nasal Polyps	☐	J33.0	Polyp of the nasal cavity	**Eosinophilic Granulomatosis with Polyangiitis (EGPA)**	☐	M30.1	Polyarteritis with lung involvement [Churg-Strauss]
	☐	J33.1	Polypoid sinus degeneration				
	☐	J33.8	Other polyp of sinus	**Other**	☐		
	☐	J33.9	Nasal polyps, unspecified				

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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?

☐ Do not triage the prescription to the Specialty Pharmacy

PRESCRIPTION: Prescriber to indicate preferred dosing regimen of NUCALA

MEDICATION			STRENGTH/FORM	QTY	REFILLS	DIRECTIONS FOR ADMINISTRATION
Office Administered	NUCALA lyophilized vial (LYO)	☐	**100 mg** of lyophilized powder in a single-dose vial for reconstitution (NDC 0173-0881-01); reconstitute with 1.2 mL of Sterile Water for Injection, USP			☐ Pediatric Severe Asthma (Patients aged 6-11 years): **40 mg** subcutaneous to upper arm, thigh, or abdomen every 4 weeks (LYO & PFS only) ☐ Severe Asthma/Nasal Polyps: **100 mg** subcutaneous to upper arm, thigh,or abdomen every 4 weeks ☐ EGPA/HES: **300 mg** subcutaneous administered as 3 separate 100-mg injections to upper arm, thigh, or abdomen every 4 weeks ☐ COPD: **100 mg** subcutaneous administered once every 4 weeks
	NUCALA prefilled syringe (PFS)	☐	**40 mg**/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)			
Home Administered	NUCALA Autoinjector (AI)	☐	**100 mg**/mL solution in a single-dose prefilled autoinjector (NDC 0173-0892-01)			
	NUCALA prefilled syringe (PFS)	☐	**100 mg**/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42)			
		☐	**40 mg**/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)			

Prescriber Declaration: I certify that the information provided above is true and that NUCALA 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 NUCALA would be collected from the patient upon treatment. I appoint the Gateway to NUCALA, 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 HERE	
	SUBSTITUTION PERMITTED (Date)	**DISPENSE AS WRITTEN* (Date)**

Optional: MyNUCALA Support

MyNUCALA offers patient services to help you begin and continue treatment with NUCALA. If enrolled, a healthcare professional[1] from the MyNUCALA Support Line will call you. The Support Line will get you on your way by answering questions you may have about NUCALA.

Give them a call: 1-844-4-NUCALA (1-844-468-2252)

[1]MyNUCALA personnel do not give medical advice. You will be directed to your healthcare provider for any disease, treatment, or referral-related questions.

MyNUCALA Support Consent:

By providing your name, address, email address, and other information including your indication below 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.

My indication (select all that apply): ☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) ☐ Severe Asthma ☐ Eosinophilic Granulomatosis with Polyangitis (EGPA) ☐ Hypereosinophilic Syndrome (HES) ☐ Chronic Obstructive Pulmonary Disease (COPD)

For additional information about how GSK handles your information, please see our privacy notice at https://privacy.gsk.com/en-us.

Email address:

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

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By signing this form, **I authorize** my doctors; pharmacies, including my Specialty Pharmacy(ies); 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 Gateway to NUCALA services or Patient Assistance Programs, which may include the following activities:

1) Communicating with my Healthcare Providers about my NUCALA 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 NUCALA 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 MyNucala Support Consent on page 1 of this form, sending me promotional information as described in the [MyNucala] 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 Gateway to NUCALA 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 P.O. Box 5490, Louisville, KY 40255. 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 Gateway to NUCALA 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 Gateway to NUCALA or GSK Patient Assistance Program services. If an authorized representative signs for the patient, please indicate relationship to the patient.