

PATIENT SECTION

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

By signing below, I **agree** to allow my doctors, pharmacies, including my specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my health information to GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing Gateway to NUCALA services, 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) Contacting me to offer (and, if I am interested, provide) optional case management and/or educational services offered by healthcare professionals; and
- 5) Disclosing my information to third parties if required by law.

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

- My Healthcare Providers will not and may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on whether I sign 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 information about me is released to GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent GSK from further disclosing my information. However, I understand that GSK has agreed to use or disclose information received only for the purposes described in this authorization or as required by law.
- This authorization will remain in effect for two (2) years after I sign it (unless a shorter period is required by state law) or for as long as I participate in the Gateway to NUCALA Program, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to P.O. Box 221797, Charlotte, NC 28222-1797, but that such a revocation would end my eligibility to participate in the Gateway to NUCALA program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date written revocation is received, but will not apply to the extent that they have already taken action in reliance on this authorization. After this authorization is revoked, I understand that information provided to GSK prior to the revocation may be disclosed within GSK to maintain records of my participation.

*The patient, or the patient's authorized representative, **MUST** sign this form to receive Gateway to NUCALA services. If an authorized representative signs for the patient, please indicate relationship to the patient.*

PATIENT SECTION

Services Requested (Check all that apply)

Patient Assistance Program (PAP) for Uninsured Patient (see pg 3) Prior Authorization Assistance Co-pay Program Claims Assistance Specialty Pharmacy (SP) Triage Bridge to NUCALA Benefits Verification

Patient Information

***Indicates required fields**

Last name*: _____ First name*: _____
 Date of birth* (mm/dd/yy): _____ City: _____ State: _____ Zip: _____
 Street: _____ Alternate contact name*: _____
 Home phone: _____ Work/cell phone: _____ Alternate contact phone*: _____
 E-mail: _____ Alternate contact relationship to patient*: _____
 Co-pay Program communication preference: Text E-mail Mail Only Language preference: English Spanish Mandarin Other:
 Patient name or caregiver (print): _____ Date: _____
 Relationship to patient: _____ MyNucala Patient Support Program (please see page 3)

PATIENT TO SIGN

PATIENT SIGNATURE REQUIRED HERE

PATIENT SIGNATURE OPTIONAL HERE

I have read and agree to the included HIPAA Patient Authorization form.

I have read and agree to the MyNucala Patient Support Program consent on page 3.

Insurance Information: Have you provided copies of all insurance cards? Medical Cards Prescription Card

Primary insurance*: Private Commercial* Medicare/Medicaid TRICARE
 Phone: _____ Policy ID #: _____ Group #: _____
Secondary insurance*: Private Commercial* Medicare/Medicaid TRICARE
 Phone: _____ Policy ID #: _____ Group #: _____
Rx Card (PBM): ID#: _____
 BIN #: _____ PCN #: _____ Group #: _____ Phone: _____
 Policyholder last name: _____ Policyholder first name: _____ Policyholder relationship to patient: _____
 Policyholder date of birth (mm/dd/yy): _____ Employer: _____

To receive optional Bridge to NUCALA support, please see page 3.

Prescriber, Acquisition, and Administration Information

***Indicates required fields**

Prescriber's last name*: _____ Prescriber's first name*: _____
 Practice name*: _____ Specialty*: _____
 Street*: _____ City*: _____ State*: _____ Zip*: _____
 Office contact name*: _____ Phone*: _____ Fax*: _____
 Prescriber Tax ID*: _____ Prescriber DEA #: _____
 Prescriber State License #: _____ Prescriber NPI #: _____ Group NPI #: _____
 Are you the prescribing physician? Yes No If no, provide name of prescribing physician: _____
How will NUCALA be acquired? Buy and Bill Specialty Pharmacy Undecided
 Site of Administration: Prescribing Physician's Office Other Physician's Office HOPD ASOC Patient administered

If NUCALA will be administered in a HOPD or ASOC, please complete the following:

Administering practice/facility: _____ Administering office contact: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____ Administering site tax ID: _____ Administering site NPI #: _____

Diagnosis and Clinical Information (Prescribed dosing regimen of NUCALA)

It is up to the provider to determine the most appropriate diagnosis code. Consult the patient's payer for coding or documentation requirements.

Diagnosis ICD10 Code*: J45.50 Severe persistent asthma, uncomplicated J45.51 Severe persistent asthma with (acute) exacerbation
 Other: _____
 Date of diagnosis (mm/dd/yy): _____ Eosinophil levels: _____ cells/mL Test date (mm/dd/yy): _____
 Exacerbations—(mm/dd/yy): _____ Unscheduled office visits (mm/dd/yy): _____ ED visits/hospitalizations—(mm/dd/yy): _____
 Allergies: _____ Comorbidities: _____

Other asthma therapies: Inhaled corticosteroids (without LABA): Current Past Oral and/or injectable corticosteroids: Current Past
 Combination therapy (ICS/LABA): Current Past Other controller (specify): _____ Current Past

Specialty Pharmacy Referral (Complete only if requesting that medication referral be triaged to Specialty Pharmacy)

New Restart Continuing Last treatment date (mm/dd/yy): _____ Next treatment date/Date needed by (mm/dd/yy): _____
 If Specialty Pharmacy selected, has the prescription already been forwarded to a Specialty Pharmacy? No Yes—which one?
Specialty Pharmacy selection is subject to health plan requirements. Request Specialty Pharmacy Triage? Yes Name: _____
 Specialty Pharmacy ship to: Patient Address Prescribing physician's office HOPD ASOC

MEDICATION	STRENGTH/Form	QTY	DIRECTIONS FOR ADMINISTRATION	REFILLS
<input type="checkbox"/> NUCALA AI	100 mg/mL solution in a single-dose prefilled autoinjector (NDC 0173-0892-01)	1	100 mg SC to upper arm, thigh, or abdomen q4wk	
<input type="checkbox"/> NUCALA PFS	100 mg/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42)	1		
<input type="checkbox"/> NUCALA LYO VIAL	100 mg of lyophilized powder in a single-dose vial for reconstitution (NDC 0173-0881-01)	1		

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

SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN*

(Date)



Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

Bridge to NUCALA Program				
MEDICATION	STRENGTH/FORM	QTY	DIRECTIONS FOR ADMINISTRATION	REFILLS
<input type="checkbox"/> NUCALA AI	100 mg/mL solution in a single-dose prefilled autoinjector (NDC 0173-0892-01)	1	100 mg SC to upper arm, thigh, or abdomen q4wk	1
<input type="checkbox"/> NUCALA PFS	100 mg/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42)	1		1
<input type="checkbox"/> NUCALA LYO VIAL	100 mg of lyophilized powder in a single-dose vial for reconstitution (NDC 0173-0881-01)	1		1

Bridge to NUCALA provides free product for eligible commercially insured patients when the PA request has been pending with the payer for more than 14 days and when other program eligibility criteria have been satisfied. Providers may not seek reimbursement for any free product provided under this program and they acknowledge that the program does not include payment for administration fees.

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 _____

SUBSTITUTION PERMITTED _____ **(Date)** **DISPENSE AS WRITTEN*** _____ **(Date)**

Optional: MyNucala Patient Support Program

GSK offers helpful services and resources to support you on your treatment journey with MyNUCALA.

GlaxoSmithKline (GSK) believes your privacy is important. By providing your name, address, phone number, email address, and other information, you are giving GSK and companies working with GSK permission to market or advertise to you 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 e-mail address to any other party for their own marketing use. For additional information regarding how GSK handles your information, please see our privacy statement.

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.

Patient Assistance Program (PAP)—Uninsured Patients

Uninsured patients who are prescribed NUCALA may be eligible for GSK's Patient Assistance Program (PAP). (Please note that this does not constitute health insurance.) To find out if you qualify, please fill in the information below.

Enroll in PAP Program **Annual pretax household income:** _____ **Number of family members living in household:** _____

PAP applicants are required to submit verification for all sources of household income at time of application, including a copy of one (1) of the following: most recent federal tax return, pay stub, W-2 statement, bank statement, or another source of income verification. This information will only be used to determine eligibility for the PAP. If you do not have one of the above-mentioned sources, please call 1-844-468-2252 for more information.

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