SERVICES REQUEST FORM

Phone: 1-844-468-2252 Fax: 1-844-237-3172

Hours of Operation: Monday through Friday, 8AM to 8PM ET

NUCALA for Eosinophilic Granulomatosis with Polyangiitis (EGPA)

IMPORTANT: This Services Request Form cannot be fully processed without both the patient and provider signing and dating this form.

GATEWAY TO NUCALA offers the following services to patients and healthcare providers (HCPs) as described below.

- **Benefits Investigation & Prior Authorization (PA) Research:** Gateway to NUCALA investigates the patient's medical and prescription benefits as well as coverage rules for the patient's insurance plan, including PA or predetermination criteria.
  IMPORTANT: Gateway to NUCALA does not submit PA requests to a Payer.
- **Specialty Pharmacy (SP) Triage:** Gateway to NUCALA will send the prescription referral to a specialty pharmacy that is in the patient's network. SP selection varies based on third-party payer requirements and patient cost-share. Patient and provider preferences will be considered where possible. If the patient has applied, and is subsequently approved, for co-pay assistance, Gateway to NUCALA also sends the patient's co-pay information to the SP.
- **Co-Pay Program:** If a commercially insured patient requests it, Gateway to NUCALA researches the patient's eligibility for the Co-pay Program for NUCALA.
- **Patient Assistance Program (PAP) for Uninsured Patients:** Uninsured patients may be eligible to receive NUCALA free of charge. If an uninsured patient requests it, Gateway to NUCALA researches the patient's eligibility for PAP. Patients must also fill out the PAP Applicants Only section on the last page of this form.
- **Prior Authorization Tracking Assistance:** Gateway to NUCALA tracks the status of a PA once submitted, and if applicable, researches reasons that the PA was denied.
- **Claims & Appeals Tracking Assistance:** Gateway to NUCALA provides details on next steps required for an appeal and tracks an appeal once submitted by the provider.

PROVIDER AND/OR PATIENT TO FILL OUT THE FOLLOWING SECTIONS:

SERVICES REQUESTED: Check the appropriate boxes on the form to request that Gateway to NUCALA perform the services requested. Once services are completed, Gateway to NUCALA will call the patient and provider to review the results. A written summary of the results will also be mailed to the patient and faxed to the provider.

INSURANCE INFORMATION: NUCALA may be covered under the medical or pharmacy benefit. Include legible copies (front and back) of the patient's medical and pharmacy insurance card(s). Include primary, secondary, Medicare/Medicaid (if eligible), and pharmacy benefit insurance information to ensure that ALL potential coverage options can be explored.

PRESCRIBER, ACQUISITION, AND ADMINISTRATION INFORMATION: Please indicate here how NUCALA will be acquired.

- **Buy and Bill:** If the provider will purchase NUCALA directly for administration in his/her office, choose this option. As described above, Gateway to NUCALA will investigate the patient's benefits and research Prior Authorization (PA) requirements.
- **Specialty Pharmacy:** If the product will be ordered through a specialty pharmacy for administration in the provider's office, please choose this option. If requesting that the prescription referral be triaged to a specialty pharmacy, check the Specialty Pharmacy Triage service on the form. Additionally, the provider will need to complete two additional sections: 1) Prescription Referral Information, and 2) Diagnosis and Clinical Information.
- **IMPORTANT:** Once Gateway to NUCALA has triaged the referral to a specialty pharmacy, the patient and provider should contact the specialty pharmacy directly to inquire about the status of the prescription referral and to coordinate any prior authorization requirements and shipping. It is important for the patient and provider to promptly return calls from the SP to minimize delays in processing the prescription.
- **Hospital Outpatient Department (HOPD)/Alternative Site of Care (ASOC):** If the patient will be receiving the injection at a location other than the provider's office, please complete the subsection that begins "If NUCALA will be administered in a HOPD or ASOC...." included in the Prescriber, Acquisition, and Administration Information section.
- **Undecided:** Select this option in the How will NUCALA be acquired section if it is not yet determined how NUCALA will be acquired. Gateway to NUCALA will investigate the patient's benefits and research PA requirements.

DIAGNOSIS AND CLINICAL INFORMATION and **PRESCRIPTION REFERRAL INFORMATION:** These two sections should be completed by the provider if Gateway will be triaging the referral to a specialty pharmacy. Otherwise, please leave blank.

BRIDGE TO NUCALA PROGRAM: When requested on behalf of a commercially insured patient, Gateway to NUCALA will research the patient's eligibility for the program. Diagnosis and Clinical Information section should be completed if the patient is being assessed for eligibility.

PATIENT OR PATIENT'S LEGAL GUARDIAN TO FILL OUT THE FOLLOWING SECTIONS:

PATIENT INFORMATION: Please fill out this section completely, including your email address and a phone number where Gateway to NUCALA may call you to review the results of the benefits investigation.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION: This allows Gateway to NUCALA to receive your information in order to provide services. Before signing, please review, understand, and agree to the terms of the authorization and release.

PATIENT ASSISTANCE PROGRAM (PAP) APPLICANTS - for uninsured patients only: Uninsured patients who would like Gateway to NUCALA to research their eligibility for PAP should fill out the PAP Applicants Only section. Otherwise, please leave blank.

PRESCRIPTION REFERRAL INFORMATION:

This section should be completed by the provider if Gateway will be triaging the referral to a specialty pharmacy. Otherwise, please leave blank.

Gateway to Nucala (mepolizumab)

SERVICES REQUEST FORM

Please complete and sign form, and fax to 1-844-237-3172

NUCALA for Eosinophilic Granulomatosis with Polyangiitis (EGPA)

SERVICES REQUESTED - CHECK ALL THAT APPLY

- ☐ Benefits Investigation & Prior Authorization Research
- ☐ Patient Assistance Program (PAP) for Uninsured Patients
- ☐ Specialty Pharmacy (SP) Triage
- ☐ Co-pay Program
- ☐ Prior Authorization Tracking Assistance
- ☐ Claims & Appeals Tracking Assistance

PATIENT INFORMATION

Last name:	First name:
Date of birth:	Gender: ☐ Female ☑ Male
Street:	City: State: ZIP:
Home phone:	Alternate contact name:
Work/cell phone:	Alternate contact phone:
E-mail:	Relationship to patient:

INSURANCE INFORMATION - Have you provided copies of all insurance cards? ☐ Medical Cards ☐ Prescription Card

PRIMARY insurance:	SECONDARY insurance:	Rx Card (PBM):	Policyholder first name:
☐ Private Commercial	☐ Private Commercial	ID #:	Policyholder last name:
☐ Medicare/Medicaid	☐ Medicare/Medicaid	BIN #:	Policyholder date of birth:
Phone:	Phone:	PCN #:	Employer:
Policy ID #:	Policy ID #:	Group #:	Relationship to patient:
Group #:	Group #:	Phone:	

PRESCRIBER, ACQUISITION, AND ADMINISTRATION INFORMATION

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 #:

How will NUCALA be acquired? ☐ Buy and Bill ☐ Specialty Pharmacy ☐ HOPD/Alternative Site of Care (ASOC) ☐ Undecided

If Specialty Pharmacy selected, has the prescription already been forwarded to a Specialty Pharmacy? ☐ No ☐ Yes – which one?

Place of Administration: ☐ Prescriber's Office ☐ HOPD ☐ Alternative Site of Care (ASOC)

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

Administering practice/physician name:	Administering office contact:
Phone: Fax:	Administering site Tax ID: Administering site NPI #:

DIAGNOSIS AND CLINICAL INFORMATION

Patient diagnosis and ICD10 code: Date of diagnosis:

Allergies: Comorbidities: Corticosteroid dose: _____ (If less than 7.5 mg please include clinical notes)

Other therapies:

☐ _____ ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____

PRESCRIPTION REFERRAL INFORMATION

☐ New ☐ Restart ☐ Continuing ☐ Last treatment date: Next treatment date/Date needed by:

Specialty Pharmacy selection is subject to health plan requirements.

Specialty Pharmacy requested: **Specialty pharmacy ship to:** ☐ **Prescribing physician's office** ☐ **HOPD** ☐ **ASOC**

MEDICATION	QTY/STRENGTH/FORM	DIRECTIONS FOR ADMINISTRATION BY HCP	REFILLS
NUCALA (mepolizumab)	☐ 3 x100 mg vial	☐ 3 separate100 mg subcutaneous injections to upper arm, thigh, or abdomen every 4 weeks	

☐ 2-mL or 3-mL syringes with 21-G needle (to mix) ☐ Sterile water for injection, USP ☐ 21-G to 27-G x 0.5-inch needle (to inject)

BRIDGE TO NUCALA PROGRAM

MEDICATION	QTY/STRENGTH/FORM	DIRECTIONS FOR ADMINISTRATION BY HCP	REFILLS
NUCALA (mepolizumab)	☐ 3 x100 mg vial	☐ 3 separate100 mg subcutaneous injections to upper arm, thigh, or abdomen every 4 weeks	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 for EPGA 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. [NY] prescribers may need to submit an electronic prescription to the specialty pharmacy.

PRESCRIBER SIGNATURE REQUIRED

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

Gateway to Nucala (mepolizumab)

SERVICES REQUEST FORM

Complete and sign this form. For assistance with any questions, please call Gateway to NUCALA at 1-844-468-2252 Monday through Friday, 8AM to 8PM ET

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

I understand that the collection, use, and disclosure of my health information are protected under law. 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 to GlaxoSmithKline and its agents and authorized representatives and any other companies that GlaxoSmithKline uses (collectively "GSK") to provide the Gateway to NUCALA the selected services related to my prescribed medication and medical condition for the purposes described below.

I understand 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 and Release.

I understand that certain Healthcare Providers, such as specialty pharmacies, may receive payment from GSK for disclosing my information to GSK for the purposes described in this authorization.

I understand that 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.

I understand that this authorization will remain in effect for two (2) years after I sign it or for as long as I participate in the Co-pay or Patient Assistance Program, whichever is longer. I also understand that I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to Gateway to NUCALA to PO Box 222173, Charlotte, NC 28222-2173, but that such a revocation would end my eligibility to participate in the programs as described. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date the 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 among GSK and the company or companies that help GSK administer the programs in order to maintain records of my participation, but it will not be otherwise disclosed or used.

Enrollment in Gateway to NUCALA (for reimbursement support and patient assistance): The patient, or the patient's authorized representative, MUST sign this form in order to receive reimbursement support and assistance from the Gateway to NUCALA. If an authorized representative signs for the patient, please indicate relationship to the patient.

By signing below, I authorize my Healthcare Providers to disclose my information to GSK to do the following:

1) Request and receive from my doctor, healthcare provider, health insurer, pharmacy or pharmacist information necessary to investigate and resolve my insurance coverage, coding, or reimbursement inquiry, or to review my eligibility for patient assistance programs and co-pay assistance;
2) Collect, use, and disclose my information for the purpose of investigating and resolving my insurance coverage, coding, or reimbursement inquiry;
3) Disclose to my treating physician, healthcare provider, pharmacy or pharmacist my information when necessary to help to resolve my insurance coverage, coding, or reimbursement inquiry;
4) Contact my insurer, other potential funding sources, and/or patient assistance programs on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them my information;
5) Contact me to determine my interest in GSK's case management program services and provide my information to the case manager program if I decide to use GSK's case management service; and
6) Disclose my information to third parties if required by law.

Patient or Legal Guardian Signature:
(please indicate relationship to the patient) SIGNATURE

Name (print): **Date:**

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 if you qualify, please fill in the information below. PATIENT TO COMPLETE

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.

Gateway to Nucala (mepolizumab)