SERVICES REQUEST FORM

Complete form, sign, and fax both pages to **1-844-237-3172**.
For assistance with any questions, please call **1-844-4-NUCALA (1-844-468-2252)**.
Monday through Friday, 8AM to 8PM ET.

Gateway to Nucala® (mepolizumab)

SERVICES REQUESTED

(Check all that apply)

- ☐ Benefits Investigation
- ☐ Co-pay Program
- ☐ Claims Assistance
- ☐ Patient Assistance Program (PAP)
- ☐ Prior Authorization Assistance

PATIENT INFORMATION

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

INSURANCE INFORMATION

Important: Fax legible copies of the front and back of all insurance cards, including medical and prescription.

PRIMARY insurance name:	SECONDARY insurance name:
Phone: ( )	Phone: ( )
Policy ID #:	Policy ID #:
Group #:	Group #:
Policyholder name:	Policyholder name:
Policyholder date of birth:	Policyholder date of birth:
Relationship to patient:	Relationship to patient:

Have you provided a copy of all insurance cards? ☐ **Medical Card** ☐ **Prescription Card**

PRESCRIBER 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 #:

If administration site is different from site of prescribing physician, please complete the following:

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

PRESCRIPTION INFORMATION

☐ New ☐ Continuing ☐ Restart

Patient diagnosis and ICD-10 code (not required for PAP):

Strength, Dosage Form for NUCALA: Next treatment date:

Quantity: Refills: Days' Supply:

Directions for Use:

Are you acquiring the product through a specialty pharmacy?

☐ Yes ☐ No ☐ Undecided

If yes, list preferred specialty pharmacy: _____

Specialty pharmacy selection will vary based on health plan requirement

Specialty pharmacy ship to: ☐ Prescribing physician's office ☐ Other:

Quantity of Supplies

☐ 28 days (1 treatment) ☐ 84-day supply (3 treatments)

Supplies from Specialty Pharmacy

- ☐ Diluent: 5 mL of preservative-free sterile water for injection, USP
- ☐ Ancillary supplies: 2-mL or 3-mL syringes with a 21-G needle for reconstitution; 1-mL syringe with a disposable 21- to 27-G x 0.5-inch (13-mm) needle for subcutaneous administration
- ☐ Other: Alcohol swab and band-aids

PRESCRIBER DECLARATION

I certify that NUCALA is being prescribed for the patient listed above. I have supplied the program operated by the Lash Group, an agent of GSK, this information to coordinate access to treatment for my patient. 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. If applicable, 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.

Prescriber Signature: PRESCRIBER SIGN HERE

Name (print): **Date:**

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

I verify that the information provided herein is true and correct. I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, and medical information, is "protected health information." By signing below, I agree to the collection, use, and disclosure of my protected health information as described below. I understand that my healthcare providers will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release. I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have 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 or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer. I also understand that I have the right to revoke this authorization at any time by calling 1-844-468-2252 or mailing a signed, written statement of my revocation to PO BOX 221797, Charlotte, NC 28222-1797, but that such a revocation would end my eligibility to participate in the programs as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that after you revoke this authorization, your information may be disclosed among GSK and the company or companies that help GSK administer the programs to maintain records of your 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 to receive reimbursement support and assistance from Gateway to NUCALA.

Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release. If an authorized representative signs for the patient, please indicate relationship to the patient. By signing below, I authorize GSK, as well as its agents and assignees and any other companies that GSK uses to administer reimbursement services for NUCALA, to do the following:

1. Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve my insurance coverage, coding, reimbursement inquiry, or review my eligibility for patient assistance programs and co-pay assistance.
2. Collect, use, and disclose to each other any information that I provide to Gateway to NUCALA for the purpose of completing my prescription fulfillment and investigating and resolving my insurance coverage, coding, or reimbursement inquiry.
3. Disclose to my treating physician, healthcare provider, or pharmacist information I provided to Gateway to NUCALA when necessary to complete my prescription fulfillment and resolve my insurance coverage, coding, or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by GSK and Gateway to NUCALA.
4. Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds and disclose to them information about my prescribed medications and medical condition that has been provided by me or my physician, healthcare provider, or pharmacist.
5. Disclose any information obtained from the sources listed above to third parties if required by law.

Patient or Legal Guardian: PATIENT/GUARDIAN SIGN HERE

Name (print): **Date:**

PATIENT ASSISTANCE PROGRAM (PAP) APPLICANTS ONLY

(Please note that this program does not constitute health insurance)

To see if you qualify for PAP, please fill in the required fields below.

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.

OPTIONAL: RECEIVE EDUCATIONAL SUPPORT

GSK offers helpful services and resources to support you on your treatment journey with NUCALA. Check the box below and provide your e-mail address if you would like to utilize these services:

☐ **By checking this box, I certify I am at least 18 years old and I am giving GSK and companies working with GSK permission to market or advertise to me about NUCALA.**

E-mail address: _____

GSK believes your privacy is important. By providing your name, address, e-mail address, and other information, you are giving GSK and companies working with GSK permission to market or advertise to you regarding the medical condition(s) in which you have expressed an interest, as well as other general 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.