

EXDENSUR Bridge Request Form



Please complete the form, sign, and FAX to: **1-844-237-3172**
For assistance, please call: **1-844-Call-TwGSK (1-844-225-5894)**
Monday–Friday, 8 AM–8 PM ET

Patients must be enrolled in Together with GSK in order to participate in the EXDENSUR Bridge Program.

The EXDENSUR Bridge Program provides free product for eligible commercially insured patients when the prior authorization request has been pending with the payer in accordance with program rules and when other program eligibility criteria have been satisfied. Providers may not seek reimbursement for any free product provided by this program. Eligibility for up to \$100 in administration fee reimbursement is available through the EXDENSUR Copay Program.

*Indicates required fields

Patient Information

Patient name*:	Date of birth (mm/dd/yyyy):		
Street address:	City:	State:	Zip:
Phone:			

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

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

Shipping Destination Details

Where should the patient's medication be shipped? Provider address (same address as above) Site of care

Shipping name/Care of:

Street address:	City:	State:	Zip:
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Prescriber signature below is required for prescription

First time on therapy: Yes No

Allergies:	Concurrent therapy:
ICD-10-CM code:	

PRESCRIPTION: EXDENSUR Bridge Program

MEDICATION	STRENGTH/Form	QTY	DIRECTIONS FOR ADMINISTRATION
HCP-Administered EXDENSUR pre-filled syringe (PFS) <input type="checkbox"/>	100 mg/mL solution single-dose pre-filled syringe (NDC 0173-0927-42)	1	Severe Asthma: <input type="checkbox"/> 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 certify that I will not seek reimbursement for any free product provided under this program. I appoint Together with GSK, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I further certify that I have made an independent clinical judgment that EXDENSUR is medically necessary for the above-named patient.

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

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