EXDENSUR Denied Coverage Request Form

together with EXDENSUR (depemokimab-ulaa)

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 to 8 PM ET

Patients must be enrolled in Together with EXDENSUR in order to be considered for the EXDENSUR Denied Coverage Program.*

*For eligible commercially insured patients, state exclusions apply. See full Terms and Conditions.

Patient Information

*Indicates required fields

Last name*:	First name*:	Date of birth (mm/dd/yyyy):
GSK patient ID *(to be completed by Together with EXDENSUR)*:		
Street address:	City:	State: Zip:
Phone:	Email*:	

Prescriber, Acquisition, and Administration Information

Last name*:		First name*:	
Practice name*:		Office contact name*:	
Street address:		City:	State: Zip:
Phone*:	Ext:	Fax*:	
Prescriber NPI #*:			
Patient is: ☐ New ☐ Restarting ☐ Continuing		Planned treatment date (mm/dd/yyyy):	

PRESCRIPTION: Denied Coverage Program

Prescriber signature required on all enrollment forms

MEDICATION		STRENGTH/FORM	QTY	REFILLS†	DIRECTIONS FOR ADMINISTRATION/QTY*
HCP-Administered	EXDENSUR pre-filled syringe (PFS)	**100 mg/mL** solution single-dose pre-filled syringe NDC 0173-0927-42	1	1	☐ **Severe Asthma** 100 mg subcutaneous to upper arm, thigh, or abdomen every six months

ICD-10-CM code:

Is the patient taking any concurrent medications? ☐ No ☐ Yes If yes, please list:

Does the patient have allergies to any medications? ☐ No ☐ Yes If yes, please list:

†Benefits will be checked before prescription fulfillment to confirm continued eligibility for the Denied Coverage Program. If fulfillment continues beyond one year, a new prescription will be required.

Shipping Destination Details

Where should the patient's medication be shipped? ☐ Provider address ☐ Site of care

Shipping name/Care of:

Street address:	City:	State:	Zip:

Which weekdays is the location able to receive shipments (choose all that apply): ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

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. **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 REQUIRED HERE

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

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GSK