# Together with GSK Oncology Enrollment Form

Fax completed enrollment form to 844-GSK-2774
For assistance, please call 1-844-4GSK-ONC (1-844-447-5662)
Monday-Friday (8 AM to 8 PM ET)

together with | Ojjaara (momelotinib)

Visit us at www.TogetherwithGSKOncology.com

## Together with GSK Oncology Services

- **Coverage Support**
  - Benefits
  - Prior Authorization Support
  - Appeals Support
  - Claims Assistance
- **Patient Assistance Program**
- **Commercial Copay Assistance**
- **Alternate Coverage Options**
  - Information About Patient Advocacy Organizations
  - Information About Independent Copay Foundations

## Patient Information

Full Name: _____

Sex: ❍ Male ❍ Female Date of Birth: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Patient Representative/Caregiver Name: _____

Patient Representative/Caregiver Relationship to Patient: _____

Patient Representative/Caregiver Phone #: _____

**Enroll in Mobile Text Notifications** (Optional):

❍ *Opt-in (include mobile phone number above)*

By providing your phone number and checking this box, you are opting in to receive SMS alerts from Together with GSK. These text messages may be generated using auto-dial at the number you submit. Message frequency varies. At any time, reply HELP for more info and STOP to end; message and data rates may apply. Refer to the Terms and Conditions and Privacy notice below or attached to the first text message. Visit https://togetherwithgsk.com/terms-and-conditions/ and https://privacy.gsk.com/en-us/privacy-notice/ for more information.

## Patient Assistance Program (PAP) for uninsured and eligible Medicare patients

**Uninsured and eligible Medicare patients** who are prescribed OJJAARA may be eligible for GSK's Patient Assistance Program. (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 pre-tax household income:** _____ **Number of family members living in household:** _____

**Medicare Beneficiary Identifier (MBI):** _____

Applicants authorize the Together with GSK Oncology PAP and its Administrators to obtain a consumer report. The consumer report, and the information derived from public and other sources, will be used to estimate income as part of the process to decide eligibility to receive free medication from GSK Oncology PAP. Upon request, GSK PAP will provide applicants with the name and address of the consumer reporting agency that provides the consumer report. The program may request additional documents and information at any time, even after enrollment, to determine if the information on the enrollment form is complete and true. For additional questions about eligibility, please contact the program.

## Marketing Opt-In (optional)

❍ GSK believes your privacy is important. By providing your name, address, email address, and other information, you are giving GSK and companies working for or with GSK permission to contact you for marketing, market research, or advertising purposes, or to invite you to interact with GSK in other ways 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 email address to any other party for their own marketing use. For additional information regarding how GSK handles your information, please see our privacy statement at https://privacy.gsk.com/en-us/. 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 or Patient Representative Name: _____ Relationship to Patient: _____

❍ I have read and agree to the **HIPAA Patient Authorization** included on page 4 **(required)**

PATIENT OR PATIENT REPRESENTATIVE TO SIGN _____

❍ I have read and agree to the **Marketing Opt-In** consent above **(optional)**

PATIENT OR PATIENT REPRESENTATIVE TO SIGN _____

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Patient Name: _____ Date of Birth: _____

## Prescriber/Facility Information

Prescriber Name: _____
Prescriber Title: _____ Specialty: _____
NPI #: _____ Tax ID #: _____
Site/Facility Name: _____
Mailing Address: _____
City: _____ State: _____ ZIP: _____
Office Contact Name: _____
Office Contact Phone #: _____ Fax #: _____
Office Contact Email: _____

## Insurance Information (check the relevant box)

Attach a copy of both sides of the patient's insurance card(s).

❍ Medicare ❍ Medicaid ❍ Commercial/Private
❍ TRICARE ❍ Other ❍ Uninsured

**Primary Insurance Payer:** _____
Insurance Name: _____
Phone #: _____ Policy ID #: _____
Group #: _____ PTAN #: _____
BIN: _____ PCN: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____
Policy Holder Relationship to Patient: _____

Has a prior authorization (PA) been initiated? ❍ Yes ❍ No
If yes, PA status: ❍ Approved ❍ Denied ❍ Pending

❍ Medicare ❍ Medicaid ❍ Commercial/Private
❍ TRICARE ❍ Other ❍ Uninsured

**Prescription Insurance Payer:** _____
Insurance Name: _____
Phone #: _____ Policy ID #: _____
Group #: _____ PTAN #: _____
BIN: _____ PCN: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____
Policy Holder Relationship to Patient: _____

Has an appeal been initiated? ❍ Yes ❍ No
If yes, PA status: ❍ Approved ❍ Denied ❍ Pending

## Preferred Specialty Pharmacy (select one)

*Not required for enrollment in Quick Start or Bridge programs.*

Preferred Specialty Pharmacy selection will be honored if permitted by patient's insurance plan.

❍ No preference
❍ In-office dispensing site
❍ Biologics by McKesson
❍ Onco360 Oncology Pharmacy

## Preferred Shipping Location (check one if shipping is needed)

❍ Patient's Address (address from section 1)
❍ Other Address (eg, provider office)

Recipient Name: _____
Phone #: _____
Street: _____
City: _____
State: _____ ZIP: _____

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Patient Name: _____ Date of Birth: _____

## Clinical Information

Treatment Start Date: _____

Primary Diagnosis: _____ Primary Diagnosis ICD-10 Code: _____

Secondary Diagnosis: _____ Secondary Diagnosis ICD-10 Code: _____

❍ Intermediate or high-risk primary myelofibrosis with anemia

❍ Intermediate or high-risk secondary myelofibrosis (post-polycythemia vera and post-essential thrombocythemia) with anemia

## Current line of therapy:

Previous Therapies: _____

Latest Hemoglobin: _____ g/dL Date of Last Transfusion: ❍ _____ ❍ N/A

Known Drug Allergies: _____

Notes: _____

## Prescription

| Medication | Strength/Form | Quantity | Refills | Directions for Administration |
|---|---|---|---|---|
| ❍ **10a. OJJAARA: Standard Prescription** | ❍ 100 mg tablet<br>❍ 150 mg tablet<br>❍ 200 mg tablet | _____ | _____ | ❍ Take 1 tablet orally once daily with or without food |
| ❍ **10b. OJJAARA: Quick Start Program**<br>*For eligible patients experiencing a delay in coverage at first dispense* | ❍ 100 mg tablet<br>❍ 150 mg tablet<br>❍ 200 mg tablet | 30 | 1 | ❍ Take 1 tablet orally once daily with or without food |
| ❍ **10c. OJJAARA: Bridge Program**<br>*For eligible patients experiencing coverage interruptions while already on treatment* | ❍ 100 mg tablet<br>❍ 150 mg tablet<br>❍ 200 mg tablet | 30 | 1 | ❍ Take 1 tablet orally once daily with or without food |

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature: _____

Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____

Date: _____

*Special Note: If a New York prescriber, please use an original New York State prescription form. The prescriber is to comply with the prescriber's state-specific prescription requirements.*

## REQUIRED: Prescriber Declaration

I certify that the information provided above is true and that OJJAARA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for OJJAARA would be collected from the patient upon treatment. I appoint Together with GSK Oncology, 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'S SIGNATURE _____ Date: _____

No stamps please.

## REQUIRED: HIPAA Patient Authorization

**By signing this form on page 1, I authorize to allow my doctors, pharmacies, including my Specialty Pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my health information ("Information") to GlaxoSmithKline and to the GSK Patient Access Programs Foundation and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and share my Information for purposes of providing Together with GSK or Patient Assistance Programs, which may include the following activities:**

1. Communicating with my Healthcare Providers about my OJJAARA 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 copay 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. Disclosing my Information to third parties if required by law;
5. Sending me educational information about OJJAARA and contacting me to describe (and, if I am interested, to provide) optional educational services offered by healthcare professionals; and
6. If I sign the OJJAARA marketing consent on page 1 of this form, sending me promotional information as described in the Marketing Opt-In paragraph on page 2 of this form.

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

- My Healthcare Providers may not condition my treatment, payment for treatment, or eligibility for or enrollment in benefits on my signing 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 my Information is released to GSK based on this authorization, federal privacy laws may no longer protect the Information from re-disclosure. However, I also understand that GSK intends to share my Information only as described in this authorization or as otherwise permitted by law.
- This authorization will remain in effect for two (2) years after I sign it or for as long as I participate in Together with GSK or the GSK Patient Assistance Program, whichever is longer, subject to any applicable state law requirement for the authorization to expire.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to **Together with GSK Oncology, 13410 Eastpoint Centre Drive Suite 150, Louisville, KY 40223**. Such a revocation will invalidate reliance on the authorization to use or disclose my Information, but will not invalidate any uses or disclosures made prior to the date my written statement of revocation is received. I understand that, even if I revoke the authorization, GSK may maintain my Information as part of records of my participation in Together with GSK and GSK Patient Assistance Program.
- I understand that I, as the patient or a legal representative signing on behalf of the patient, have a right to receive a copy of this signed form.

**The patient, or the patient's authorized representative, MUST sign this form (page 1) in order for the patient to receive Together with GSK or GSK Patient Assistance Program services. If an authorized representative signs for the patient, please indicate relationship to the patient.**

**Please provide a signed copy of this form to the patient.**


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GSK