Together with GSK Enrollment Form

Fax completed enrollment form to 833-ZEJULA0 (833-935-8520)
For assistance, please call 1-844-4GSK-ONC (1-844-447-5662)
Monday-Friday (8 AM to 8 PM ET)

together with Zejula niraparib

Visit us at www.TogetherwithGSK.com

An electronic Enrollment Form is available online.
Scan the QR code to access Together with GSK.

Program services include:

- Benefits Investigation (Pharmacy and/or Medical Insurance Coverage)
- Home Health Coverage Information
- Commercial Copay Assistance Program
- Prior Authorization and Appeals Support
- Quick Start and Bridge Programs
- Patient Assistance Program
- Alternative Funding Sources Information
- Patient Advocacy Organization Information

Patient Information

*Indicates required fields.

Last name*:		First name*:
Street*:		City*:
State*:	Zip*:	Email*:
Date of birth* (mm/dd/yyyy):		Language preference (if other than English):
Gender (at birth): ○ Male ○ Female		Alternate contact name:
Preferred phone#*:	○ Home ○ Mobile	Alternate contact phone:
Preferred time to contact: ○ Morning ○ Afternoon ○ Evening		Alternate contact relationship to patient:
OK to leave a detailed voicemail?: ○ Yes		

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.

Insurance Information (Please provide front and back copies of all insurance cards)

○ No Insurance	Primary Insurance	Secondary Insurance
Insurance provider		
Insurance phone		
Cardholder name (if not the patient)		
Cardholder DOB		
Policy #		
Group #		

Patient Authorization (REQUIRED) and Marketing Opt-In Consent (Optional)

Print patient or caregiver name: _____ Relationship to patient: _____

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

PATIENT TO SIGN PATIENT SIGNATURE HERE Date (mm/dd/yyyy): _____

I have read and agree to the Marketing Opt-in consent included on page 2 (optional)

PATIENT TO SIGN PATIENT SIGNATURE HERE Date (mm/dd/yyyy): _____

Patient name: _____ Date of birth (mm/dd/yyyy): _____

Patient Assistance Program* (PAP) for Uninsured and Eligible Medicare Patients (Optional)

Uninsured and underinsured patients who are prescribed ZEJULA may be eligible for GSK's Patient Assistance Program (PAP). (Please note that this does not constitute health insurance.) To find out if you qualify, please fill in the information below.

Medicare patients applying for the PAP must provide their Medicare Beneficiary Identifier (MBI) found on their government-issued Medicare Health Insurance Card. It is 11 characters made up of letters and numbers (eg, 1EG4-TE5-MK73)

Medicare Beneficiary Identifier (MBI): _____

❍ Enroll in PAP

Annual pre-tax household income: _____ Number of family members living in household: _____

Applicants authorize the Together with GSK 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 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. Patients who participate or are enrolled in an Alternate Funding Plan are not eligible for GSK PAP. For additional questions about eligibility, please contact the program or GSKPAF.org.

*The GSK Patient Assistance Program is operated by the GSK Patient Access Programs Foundation, an independent non-profit organization separate from GSK.

Marketing Opt-in (Optional)

GSK offers helpful services and resources that help you begin and continue treatment with ZEJULA. GSK believes your privacy is important. By providing your name, address, email address, and other information including your indication below, 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.

ZEJULA indication: (check all that apply)

❍ Advanced ovarian cancer, fallopian tube cancer, or primary peritoneal cancer (HRD-positive, first-line maintenance)

❍ Recurrent *BRCA*-mutated ovarian cancer, fallopian tube cancer, or primary peritoneal cancer

For additional information regarding how GSK handles your information, please see our privacy notice 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.

Email address: _____

REQUIRED: Prescriber Declaration

I certify that the information provided on page 3 is true and that ZEJULA 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 ZEJULA would be collected from the patient upon treatment. I appoint Together with GSK, 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 TO SIGN

PRESCRIBER SIGNATURE HERE _____ Date (mm/dd/yyyy): _____

Patient name: _____ Date of birth (mm/dd/yyyy): _____

Prescriber/Site Information (REQUIRED)

*Indicates required fields.

Prescriber last name*:		First name*:	Specialty:
Tax ID#*:	NPI#*:	State license#*:	
Practice name*:			
Street*:	City*:	State*:	Zip*:
Office contact name*:		Phone*:	Ext*:
Office contact email*:		Fax*:	

Preferred Specialty Pharmacy

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
- ○ Accredo Health Group, Inc.
- ○ Biologics McKesson
- ○ CVS Specialty Pharmacy
- ○ Optum Specialty Pharmacy

Preferred Shipping Location

(check one if shipping is needed)

- ○ Patient's address (address from page 1)
- ○ Other address (eg, provider office)

Recipient's name:

Street:

City: State: Zip:

Clinical Information

Treatment start date: ___MM___ / ___DD___ / ___YYYY___

Primary diagnosis:	Primary diagnosis ICD-10 code:
Secondary diagnosis:	Secondary diagnosis ICD-10 code:
Current line of therapy: ○ 1st line ○ 2nd line ○ 3rd line ○ 4th line+	*BRCA* test: ○ Positive ○ Negative ○ Results pending
	HRd test: ○ Positive ○ Negative ○ Results pending
Known drug allergies:	
Notes:	

Prescription

Medication	Strength/Form	Quantity	Refills	Directions for Administration
❍ **ZEJULA: Standard Prescription**	○ 100 mg tablets PO daily ○ 200 mg tablets PO daily ○ 300 mg tablets PO daily	_____	_____	Take 1 tablet by mouth, with or without food, at the same time each day (preferably in the evening)
❍ **ZEJULA: Quick Start Program** *For eligible patients experiencing a delay in coverage at first dispense*	○ 100 mg tablets PO daily ○ 200 mg tablets PO daily ○ 300 mg tablets PO daily	30	1	
❍ **ZEJULA: Bridge Program** *For eligible patients experiencing coverage interruptions while already on treatment*	○ 100 mg tablets PO daily ○ 200 mg tablets PO daily ○ 300 mg tablets PO daily	30	1	

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's signature: SIGNATURE HERE	Prescriber's signature: SIGNATURE HERE
Date: ___MM___ / ___DD___ / ___YYYY___	Date: ___MM___ / ___DD___ / ___YYYY___

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.
PO = orally.

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Visit us at www.TogetherwithGSK.com

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

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 (my "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 ZEJULA 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 ZEJULA 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 ZEJULA 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, 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.

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Produced in USA.

GSK