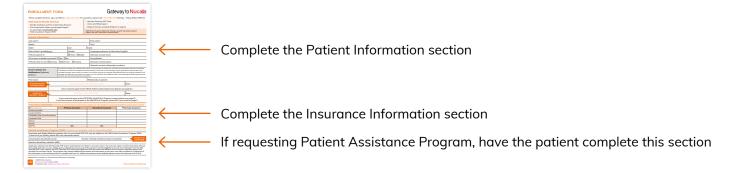


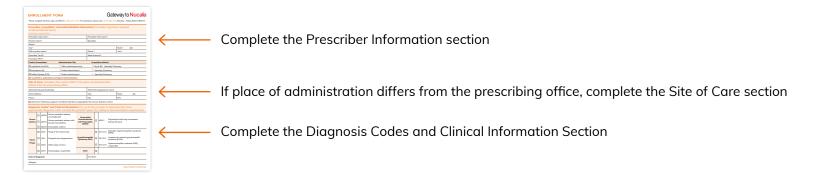
Please complete the form, sign, and FAX to 1-844-237-3172. For assistance, please call 1-844-468-2252 Monday – Friday, 8AM to 8PM ET.

Important instructions for completing the Gateway to Nucala Enrollment Form

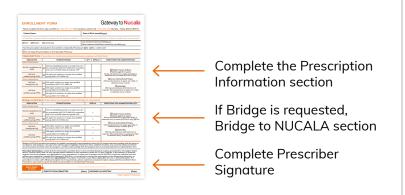
Step 1: Patient Information (Page 2)



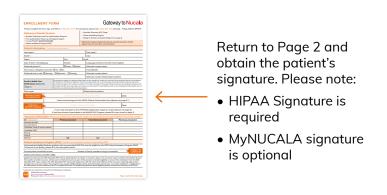
Step 2: Prescriber Information (Page 3)



Step 3: Prescription Information (Page 4)



Step 4: Patient Consent and Signature (Page 2)



Next Steps



Provide a signed copy of this form to the patient



Fax completed enrollment form to 1-844-237-3172 or submit electronically to Gateway for Nucala at www.GatewaytoNucala.com

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Gateway to Nucala

Please complete the form, sign, and FAX to 1-844-237-3172. For assistance, please call 1-844-468-2252 Monday – Friday, 8AM to 8PM ET.

Gateway to Nucala Services

- Benefits Verification and Prior Authorization Research
- Prior Authorization Follow-up and Appeal Support
- Co-pay Program (commercial only)
- Patient Assistance Program (PAP)

Specialty Pharmacy (SP) Triage

- · Claims and Billing Support
- Bridge to NUCALA (complete Bridge Rx on page 4)

MyNUCALA Support (Optional): Disease-specific education, patient support services, and other communication

Patient Information *Indica	tes required	fields					
Last name*:				First name*:			
Street*:				City*:			
State*:		Zip*:	Em	nail:			
Date of birth* (mm/dd/yyyy):		Gender:		Language preference (if other t	han Englis	sh):	
Preferred phone #*:		☐ Home ☐ Mobile		Alternate contact name:			
OK to leave a detailed voicemail?	☐ Yes ☐ N	0		Home/Mobile:			
Preferred time to call: ☐ Morning	☐ Afterno	on 🗆 Evening		Alternate contact phone:			
<u> </u>				Alternate contact relationship t	o patient:		
Notifications (Optional): in Gateway to NUCALA via telephone and to recorded messages at the number you subm				d its service providers to contact you and send communications about your enrollment ext message. These calls or text messages may be generated using auto-dial or preit. The number and type of messages will be based upon your program selections, and ime, you may request to stop telephone calls or text messages by following the opt-out			
Print name:			Re	elationship to patient:			
GATEWAY PATIENT AUTHORIZATION*		PATIENT SIGNATUR	RE F	REQUIRED HERE	Date:		
	I have r	read and agree to the I	HIPA	AA Patient Authorization form (p	lease see	page 6).*	
MYNUCALA SUPPORT CONSENT		PATIENT SIGNATURE HERE			Date:		
I have read and agree to the OPTIONAL MyNUCALA Support consent (please see page 5). If you have chosen to participate in the MyNUCALA Program, please fill in your email on page 5.							
*Insurance Information: Ple	ease provi	de front and back	СО	pies of all medical and pro	escriptio	n insurance cards	
□ No insurance Pri		nary insurance		Secondary insurance	Pho	armacy insurance	
Insurance provider							
Insurance phone							
Cardholder name (if not the patient)							
Cardholder DOB	Cardholder DOB						
Policy #							
Group #							
BIN/PCN		N/A		N/A			
Patient Assistance Program	n (PAP): F	Patient to complet	e o	nly if requesting PAP			

Uninsured and eligible Medicare patients who are prescribed NUCALA may be eligible for the GSK Patient Assistance Program (PAP). To find out if you qualify, please fill in the information below.

Annual pretax household income:

Number of family members living in household:

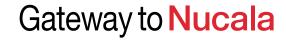
COMPLETE

Medicare Beneficiary Identifier (MBI):

Applicants authorize the GSK Specialty 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 the GSK Specialty PAP. Upon request, the GSK Specialty 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 Gateway to NUCALA.

Trademarks are owned by or licensed to the GSK group of companies.





Please complete the form, sign, and FAX to 1-844-237-3172. For assistance, please call 1-844-468-2252 Monday – Friday, 8AM to 8PM ET.

		•	iisition, and Administrati t forms	on Inform	nation:	Pre	escriber	signatu	re require	d	
*Indicates											
Prescribe		-			Prescrib	er's	first name*	·			
Practice n	ame	e*:			Specialt	ty:					
Street*:											
City*:									State*:	Zip*:	
Office con	itac	t name*:			Phone*:			Ext:	Fax*:		
Prescribe	r Tax	x ID*:			State lic	ense	e # * :				
Prescribe	r NP	rl #*:									
Product F	orm	nulation*	Administration Site		Acc	quisi	tion Metho	d			
☐ Lyophili	ized	vial (LYC	O) → Office administer	ed only	\rightarrow	Buy	& Bill →	Specialty I	Pharmacy		
□ Autoinj	ecto	or (AI)	→ Patient administe	ered	\rightarrow	Spe	cialty Phar	macy			
☐ Prefilled	d Sy	ringe (PF	→ Patient administe	ered	\rightarrow	Spe	cialty Phar	macy			
□I would	like	to unde	rstand coverage for all formulation	ns.							
			nplete this section ONLY prescribing office	if the pla	ice of c	ıdm	ninistrati	on			
Administe	ering	g practice	e/facility:		Administering physician name:						
Street add	dres	s:			City:		State: Zip:				
Phone: Ext:			Fax:		NPI:						
☐ Check here if Gateway support is needed to identify an appropriate S				e Site of	Care	e (infusion c	enter)				
_			s* and Clinical Information								ts.
		J45.50	Severe persistent asthma, uncomplicated	Eosinop Granulom	ohilic					-	
Severe Asthma		J45.51	Severe persistent asthma with (acute) exacerbation	with Polyo (EGP)	angiitis		M30.1	[Churg-St	itis with lung i rrauss]	invoivement	
		J82.83	Eosinophilic asthma								
		J33.0	Polyp of the nasal cavity				D72.110	Idiopathic [IHES]	c hypereosino	philic syndrome	
Nasal		J33.1	Polypoid sinus degeneration	Hypereosir Syndrome			D72.111	Lymphocy syndrome		pereosinophilic	
Polyps		J33.8	Other polyp of sinus				D72.119	Hypereos unspecifie	inophilic synd ed	frome [HES],	
		J33.9	Nasal polyps, unspecified	Othe	er						
Date of D	iagı	nosis:									
Allergies:											

Gateway to Nucala

Please complete the form, sign, and FAX to 1-844-237-3172. For assistance, please call 1-844-468-2252 Monday – Friday, 8AM to 8PM ET.

Patient Name:		Date of Bi	rth (mm/do	d/yyyy):
Prescriber signature	below is required for Rx and/or enrollment •	Specialty Ph	armacy se	lection is subject to health plan requirements
□ New □ Restart	□ Continuing		•	nm/dd/yyyy): vate needed by (mm/dd/yyyy):
Has the prescription all	ready been forwarded to a Specialty Pharmac	y? □No □	Yes—which	n one?
\square Do not triage the pre	scription to the Specialty Pharmacy			
PRESCRIPTION: F	Prescriber to indicate preferred dos	ng regim	en of NU	ICALA
MEDICATION	STRENGTH/FORM	QTY	REFILLS	DIRECTIONS FOR ADMINISTRATION
Office Administered				
NUCALA lyophilized vial (LYO)	100 mg of lyophilized powder in a single-dose vi for reconstitution (NDC 0173-0881-01); reconstitution with 1.2 mL of Sterile Water for Injection, USP			☐ Pediatric Severe Asthma (Patients aged 6-11 years):
NUCALA prefilled syringe (PFS)	40 mg/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)	d		40 mg subcutaneous to upper arm, thigh,or abdomen every 4 weeks (LYO & PFS only)
Home Administered				☐ Severe Asthma/Nasal Polyps:
NUCALA Autoinjector (AI)	100 mg/mL solution in a single-dose prefilled autoinjector (NDC 0173-0892-01)			100 mg subcutaneous to upper arm, thigh, or abdomen every 4 weeks ☐ EGPA/HES:
NUCALA	□ 100 mg/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42)			300 mg subcutaneous administered as 3 separate 100-mg injections to upper arm,
prefilled syringe (PFS)	40 mg/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)	d		thigh, or abdomen every 4 weeks
Bridge to NUCAL	A: Prescriber to complete only if Bri	dge is red	quested	
MEDICATION	STRENGTH/FORM	RE	FILLS	DIRECTIONS FOR ADMINISTRATION /QTY
Office Administered				
NUCALA lyophilized vial (LYO)	100 mg of lyophilized powder in a single-dose vi for reconstitution (NDC 0173-0881-01); reconstit with 1.2 mL of Sterile Water for Injection, USP		1	☐ Pediatric Severe Asthma (Patients aged 6-11 years):
NUCALA prefilled syringe (PFS)	40 mg/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)	d	1	40 mg subcutaneous to upper arm, thigh, or abdomen every 4 weeks (LYO & PFS only). QTY: 1
Home Administered		'		Severe Asthma/Nasal Polyps:
NUCALA Autoinjector (AI)	100 mg/mL solution in a single-dose prefilled autoinjector (NDC 0173-0892-01)		1	100 mg subcutaneous to upper arm, thigh, or abdomen every 4 weeks. QTY: 1
NUCALA	100 mg/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42)		1	☐ EGPA/HES: 300 mg subcutaneous administered as 3 separate 100-mg injections to upper arm,
prefilled syringe (PFS)	40 mg/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)	d	1	thigh, or abdomen every 4 weeks. QTY: 3
Bridge to NUCALA prov	rides free product for eligible commercially insur	ed patients	when the P	A request has been pending with the payer in

Bridge to NUCALA provides free product for eligible commercially insured patients when the PA 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 under this program, and they acknowledge that the program does not include payment for administration fees.

Prescriber Declaration: I certify that the information provided above is true and that NUCALA is being prescribed for the patient listed above. 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. 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. Prescribers may need to submit an electronic prescription to the Specialty Pharmacy.

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

Gateway to Nucala

What happens next?

1.

We contact your insurance

We will investigate your benefits and help you understand your coverage options for NUCALA. Typically, it takes about two business days for application processing.



2

We will contact you

A representative will call you to help you understand your plan's current coverage, out-of-pocket costs, and financial assistance options (if eligible). A summary of this benefit information will be sent to you and your healthcare provider. The information provided by the Gateway is not a guarantee of coverage.



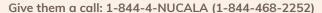
What's next?

Look out for a phone call. You may not recognize the number, but it could be a call about your prescription.

Call your doctor. If you don't hear anything within the next two weeks, contact your doctor's office to check on the status of your prescription.

Optional: MyNUCALA Support

MyNUCALA offers patient services to help you begin and continue treatment with NUCALA. If enrolled, a healthcare professional* from the MyNUCALA Nurse Support Line will call you. The Support Line will get you on your way by answering questions you may have about NUCALA.



*MyNUCALA personnel do not give medical advice. You will be directed to your healthcare provider for any disease, treatment, or referral-related questions.



3

MyNUCALA Support Consent:

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.

My indication (select all that apply)

	Severe	Astl	hma
--	--------	------	-----

- ☐ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
- ☐ Eosinophilic Granulomatosis with Polyangitis (EGPA)
- ☐ Hypereosinophilic Syndrome (HES)

For additional information about how GSK handles your information, please see our privacy notice at https://privacy.gsk.com/en-us.

Email address:

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.

Questions? Call 1-844-4-NUCALA (1-844-468-2252). Representatives are available Monday - Friday, 8AM to 8PM ET.

Gateway to Nucala

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

By signing this form, I agree to allow my doctors; pharmacies, including my Specialty Pharmacy(ies); and health insurers (collectively "Healthcare Providers") to use and disclose my health information to GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing Gateway to NUCALA services, which may include the following activities:

- 1) Communicating with my Healthcare Providers about my NUCALA prescription and medical condition;
- Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for GSK's patient assistance and co-pay 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) Contacting me to offer (and, if I am interested, provide) optional educational services offered by healthcare professionals; and
- 5) Disclosing my information to third parties if required by law.

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

- My Healthcare Providers will not and may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on whether I sign 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 information about me is released to GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent GSK from further disclosing my information. However, I understand that GSK has agreed to use or disclose information received only for the purposes described in this authorization or as required by law.
- This authorization will remain in effect for two (2) years after I sign it (unless a shorter period is required by state law) or for as long as I participate in the Gateway to NUCALA Program, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to P.O. Box 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in the Gateway to NUCALA program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date written revocation is received but will not apply to the extent that they have already taken action in reliance on this authorization. After this authorization is revoked, I understand that information provided to GSK prior to the revocation may be disclosed within GSK to maintain records of my participation.
- I understand that I, as the patient or signer, have a right to receive a copy of this signed form.

The patient, or the patient's authorized representative, MUST sign this form to receive Gateway to NUCALA services. If an authorized representative signs for the patient, please indicate relationship to the patient.

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