

ENROLLMENT FORM

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)

Scan to save contact information
for Gateway to NUCALA



Gateway to NUCALA Services

- Benefits Verification and Prior Authorization Research
- Patient Assistance Program (PAP)
- Prior Authorization Follow-up and Appeal Support
- Specialty Pharmacy (SP) Triage
- Co-pay Program (commercial only)
- Claims and Billing Support
- **Bridge to NUCALA:** Complete Bridge Rx on page 3
- **MyNUCALA Support (Optional):** Disease-specific education, patient support services, and other communication

*Indicates required fields

Patient Information

Last name*:		First name*:	
Street*:		City*:	
State*:	Zip*:	Email:	
Date of birth* (mm/dd/yyyy):	Gender:	Language preference (if other than English):	
Preferred phone #*:	<input type="checkbox"/> Home <input type="checkbox"/> Mobile	Alternate contact name:	
OK to leave a detailed voicemail? <input type="checkbox"/> Yes		Home/Mobile:	
Preferred time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		Alternate contact phone:	
		Alternate contact relationship to patient:	

Enroll in Mobile Text Notifications (Optional):

Opt-in (include mobile phone number above)

By opting into texting you authorize GSK and its service providers to contact you and send communications about your enrollment in Gateway to NUCALA via telephone and text message. These calls or text messages may be generated using auto-dial or pre-recorded messages at the number you submit. The number and type of messages will be based upon your program selections, and message and data rates may apply. At any time, you may request to stop telephone calls or text messages by following the opt-out directions provided during those communications.

Print name:	Relationship to patient:
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GATEWAY PATIENT AUTHORIZATION*



PATIENT SIGNATURE REQUIRED HERE

Date:

I have read and agree to the HIPAA Patient Authorization form (please see page 4).*

MYNUCALA SUPPORT CONSENT



PATIENT SIGNATURE HERE

Date:

I have read and agree to the OPTIONAL MyNUCALA Support consent (please see page 2).
If you have chosen to participate in the MyNUCALA Program, please fill in your email on page 2.

*Insurance Information: Please provide front and back copies of all medical and prescription insurance cards

<input type="checkbox"/> No insurance	Primary insurance	Secondary insurance	Pharmacy insurance
Insurance provider			
Insurance phone			
Cardholder name (if not the patient)			
Cardholder DOB			
Policy #			
Group #			
BIN/PCN	N/A	N/A	

Is a Prior Authorization on file with the Payer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorization #:	Expiration Date:
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Patient Assistance Program[†] (PAP): Patient to complete only if requesting PAP

Uninsured and eligible Medicare patients who are prescribed NUCALA may be eligible for GSK's 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:	PATIENT TO 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. 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 Gateway to NUCALA or GSKforYOU.com.

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

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*Indicates required fields

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

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

Product Formulation (choose one)*	Administration Site	Acquisition Method	
<input type="checkbox"/> Lyophilized Vial (LYO)	→ Office administered only	<input type="checkbox"/> Buy & Bill	<input type="checkbox"/> Specialty Pharmacy
<input type="checkbox"/> Autoinjector (AI)	→ Patient administered	→ Specialty pharmacy	
<input type="checkbox"/> Prefilled Syringe (PFS)	→ Patient administered	→ Specialty pharmacy	

Site of Care: Complete this section ONLY if the place of administration differs from the prescribing office

Administering practice/facility:	Administering physician name:		
Street address:	City:	State:	Zip:
Phone:	Ext:	Fax:	NPI:

Check here if Gateway support is needed to identify an appropriate Site of Care (infusion center)

*Diagnosis Codes and Clinical Information: It is up to the provider to determine the most appropriate diagnosis code. Consult the patient's payer for coding or documentation requirements.

Severe Asthma	<input type="checkbox"/>	J45.50	Severe persistent asthma, uncomplicated	Eosinophilic Granulomatosis with Polyangiitis (EGPA)	<input type="checkbox"/>	M30.1	Polyarteritis with lung involvement [Churg-Strauss]
	<input type="checkbox"/>	J45.51	Severe persistent asthma with (acute) exacerbation				
	<input type="checkbox"/>	J82.83	Eosinophilic asthma				
Nasal Polyps	<input type="checkbox"/>	J33.0	Polyp of the nasal cavity	Hypereosinophilic Syndrome (HES)	<input type="checkbox"/>	D72.110	Idiopathic hypereosinophilic syndrome [IHES]
	<input type="checkbox"/>	J33.1	Polypoid sinus degeneration				
	<input type="checkbox"/>	J33.8	Other polyp of sinus				
	<input type="checkbox"/>	J33.9	Nasal polyps, unspecified	Other	<input type="checkbox"/>		

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.

Give them a call: **1-844-4-NUCALA (1-844-468-2252)**

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

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): Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) Severe Asthma
 Eosinophilic Granulomatosis with Polyangiitis (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.

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Patient Name:	Date of Birth (mm/dd/yyyy):
<ul style="list-style-type: none"> • Prescriber signature below is required for Rx and/or enrollment • Specialty Pharmacy selection is subject to health plan requirements 	
<input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing	Last treatment date (mm/dd/yyyy): Next treatment date/Date needed by (mm/dd/yyyy):
Has the prescription already been forwarded to a Specialty Pharmacy? <input type="checkbox"/> No <input type="checkbox"/> Yes—which one?	
<input type="checkbox"/> Do not triage the prescription to the Specialty Pharmacy	

PRESCRIPTION: Prescriber to indicate preferred dosing regimen of NUCALA

MEDICATION		STRENGTH/Form	QTY	REFILLS	DIRECTIONS FOR ADMINISTRATION
Office Administered	<input type="checkbox"/>	NUCALA lyophilized vial (LYO) 100 mg of lyophilized powder in a single-dose vial for reconstitution (NDC 0173-0881-01); reconstitute with 1.2 mL of Sterile Water for Injection, USP			<input type="checkbox"/> Pediatric Severe Asthma (Patients aged 6-11 years): 40 mg subcutaneous to upper arm, thigh, or abdomen every 4 weeks (LYO & PFS only) <input type="checkbox"/> Severe Asthma/Nasal Polyps: 100 mg subcutaneous to upper arm, thigh, or abdomen every 4 weeks
	<input type="checkbox"/>	NUCALA prefilled syringe (PFS) 40 mg/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)			
Home Administered	<input type="checkbox"/>	NUCALA Autoinjector (AI) 100 mg/mL solution in a single-dose prefilled autoinjector (NDC 0173-0892-01)			<input type="checkbox"/> EGPA/HES: 300 mg subcutaneous administered as 3 separate 100-mg injections to upper arm, thigh, or abdomen every 4 weeks
	<input type="checkbox"/>	NUCALA prefilled syringe (PFS) 100 mg/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42)			
	<input type="checkbox"/>	NUCALA prefilled syringe (PFS) 40 mg/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)			

Bridge to NUCALA: Prescriber to complete only if Bridge is requested

MEDICATION		STRENGTH/Form	REFILLS	DIRECTIONS FOR ADMINISTRATION/QTY
Office Administered	<input type="checkbox"/>	NUCALA lyophilized vial (LYO) 100 mg of lyophilized powder in a single-dose vial for reconstitution (NDC 0173-0881-01); reconstitute with 1.2 mL of Sterile Water for Injection, USP	1	<input type="checkbox"/> Pediatric Severe Asthma (Patients aged 6-11 years): 40 mg subcutaneous to upper arm, thigh, or abdomen every 4 weeks (LYO & PFS only). QTY: 1 <input type="checkbox"/> Severe Asthma/Nasal Polyps: 100 mg subcutaneous to upper arm, thigh, or abdomen every 4 weeks. QTY: 1
	<input type="checkbox"/>	NUCALA prefilled syringe (PFS) 40 mg/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)	1	
Home Administered	<input type="checkbox"/>	NUCALA Autoinjector (AI) 100 mg/mL solution in a single-dose prefilled autoinjector (NDC 0173-0892-01)	1	<input type="checkbox"/> EGPA/HES: 300 mg subcutaneous administered as 3 separate 100-mg injections to upper arm, thigh, or abdomen every 4 weeks. QTY: 3
	<input type="checkbox"/>	NUCALA prefilled syringe (PFS) 100 mg/mL solution in a single-dose prefilled syringe (NDC 0173-0892-42)	1	
	<input type="checkbox"/>	NUCALA prefilled syringe (PFS) 40 mg/0.4 mL solution in a single-dose prefilled syringe (NDC 0173-0904-42)	1	

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)

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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 GSK and to the GSK Patient Access Programs Foundation 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 or Patient Assistance Programs, which may include the following activities:

- 1) Communicating with my Healthcare Providers about my NUCALA 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 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 or the GSK Patient Assistance 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 and the GSK Patient Assistance 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 or GSK Patient Assistance Program services. If an authorized representative signs for the patient, please indicate relationship to the patient.*