



Together with GSK Oncology Enrollment Form

Fax completed enrollment form to 1-844-475-4662 For assistance, please call 1-844-4GSK-ONC Monday-Friday (8 AM to 8 PM ET)

Page 1 of 5

Important Instructions:

Visit us at www.TogetherwithGSKOncology.com



Complete pages 2-4 of the Together with GSK Oncology Enrollment Form. Patient to sign section 6 on page 3. Healthcare professional to sign and date section 11 on page 4. Fax the completed and signed enrollment form, plus copies of your patient's medical and pharmacy insurance cards, to 1-844-475-4662.

Patient Information (see pages 2 and 3)

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Section 1: Select the services you are requesting.

Section 2: Complete the Patient Information.

Section 4 (optional – for eligible co-pay patients only): If you'd like to receive communications about your co-pay enrollment via telephone or text message, check the box to enroll.

Section 5 (optional): If you'd like to see if you're eligible for GSK's Patient Assistance Program (PAP), check the box to enroll, complete PAP information to research eligibility.

Section 6: Read HIPAA Patient Authorization on page 5, check the box, sign, and date.

Next steps: Together with GSK Oncology will call patients within 2 business days to provide coverage information for their prescribed treatment and offer co-pay assistance options for eligible patients.

Prescriber Information (see pages 2 and 4)

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Section 3: Coverage for the product may be available under the medical or pharmacy benefit. Include legible copies (front and back) of the patient's medical and pharmacy insurance card(s). Include primary, secondary, Medicare/Medicaid (if eligible), and pharmacy benefit insurance information to ensure that ALL potential coverage options can be explored.

Section 7: Provide the Prescriber/Facility Information.

Section 8 (optional): Please include practice email if you would like the Together with GSK Oncology Co-pay Program to provide payment to the provider on behalf of eligible enrolled patients via EFT.

Section 9: Identify preferred shipping location if different than section 8.

Section 10: Clinical information is very important and often requested when verifying benefits. Diagnosis and appropriate ICD-10 code are required fields.

Section 11: Read Prescriber Declaration, sign, and date. A healthcare professional's signature is required.

Next steps: Together with GSK Oncology will confirm receipt by the next business day and conduct a summary of benefits call within 1-2 business days. Healthcare professionals will be notified regarding contact preferences and Together with GSK Oncology service options for patients.

Together with GSK Oncology Services:

- Coverage Support
 - Benefits Investigation
- Prior Authorization Support
- Appeals Support
- Claims Assistance

- Patient Assistance Program
- Commercial Co-pay Assistance
- Alternate Coverage Options
- Information About Patient Advocacy Organizations
- Information About Independent Co-pay Foundations

Together with GSK Oncology Enrollment Form Fax completed enrollment form to 1-844-475-4662 GSK For assistance, please call 1-844-4GSK-ONC Jemperli Monday-Friday (8 AM to 8 PM ET) Together with **GSK Oncology** (dostarlimab-gxly) Injection 500 mg Page 2 of 5 Visit us at www.TogetherwithGSKOncology.com **Check for Services Requested** 1 O Coverage Support O Patient Assistance Program O Alternate Coverage Support O Commercial Co-pay Assistance (review section 4 for texting options) 2 Patient Information

First Name:	Last Name:				
Sex: O Male O Female Date of Birth: MM DD YYYY					
Patient Address:	City: State: ZIP:				
Home Phone #:	Cell Phone #:				
Email:					
Best Time to Contact: O AM (8 AM to 10 AM) O Day (10 AM to	5 рм) OPM (after 5 рм)				
Alt. Contact Name:					
Alt. Contact Relationship to Patient:					
Alt. Contact Phone #:					

Insurance Information 3

Include a copy of both sid	es of the patient's insurance card(s).
Check Appropriate Box	
Medicare Medicaid Commercial/Private O	ther O Uninsured
Primary Insurance Payer:	
Insurance Name:	
Phone #:	
Policy ID #:	_ Group #:
BIN:	_ PCN:
Policy Holder Name:	Policy Holder Date of Birth: / /
Policy Holder Relationship to Patient:	
Check Appropriate Box	
	ther O Uninsured
 Medicare ○ Medicaid ○ Commercial/Private ○ O 	ther O Uninsured
Medicare Medicaid Commercial/Private O Secondary Insurance Payer:	
Medicare Medicaid Commercial/Private O Secondary Insurance Payer: Insurance Name:	
Medicare Medicaid Commercial/Private O Secondary Insurance Payer: Insurance Name: Phone #:	
Medicare Medicaid Commercial/Private O Secondary Insurance Payer:	
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GSK		Fax completed enrollment form to 1-844-475-4662
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Together with	(dostarlimab-gxly) Injection 500 mg	Monday-Friday (8 ам to 8 рм ET)
GSK Oncology		Page 3 of 5
		Visit us at www.TogetherwithGSKOncology.com
Patient Name:		Date of Birth: / /
4 Texting Opt-in (0	Commercial Co-pay Assistance On	y–Rates May Apply)
you and send comm generated using aut	nunications about your co-pay enrolline o-dial or pre-recorded messages at the	Co-pay Program, you authorize GSK and its service provider to contact ent via telephone and text message. These calls or text messages may be a number you submit. Message and data rates may apply. At any time, you collowing the opt-out directions provided during those communications.
5 Patient Assistan	ce Program (PAP) for Uninsured a	nd Eligible Medicare Patients (Optional)
		EMPERLI may be eligible for GSK's Patient Assistance Program (PAP). o find out if you qualify, please fill in the information below.
	ying for PAP must provide their Medica s made up of letters and numbers (ex.	are Beneficiary Identifier (MBI) found on their Medicare Health Insurance 1EG4-TE5-MK73)
Patient MBI:		
O Enroll in PAP Progr	am Annual pre-tax household inco	me: Number of family members living in household:
and the information de to receive free medicat consumer reporting ag time, even after enrolln	rived from public and other sources, w ion from GSK Oncology PAP. Upon rec ency that provides the consumer repor	nd its Administrators to obtain a consumer report. The consumer report, ill be used to estimate income as part of the process to decide eligibility quest, GSK PAP will provide applicants with the name and address of the rt. The program may request additional documents and information at any the enrollment form is complete and true. For additional questions about
6 REQUIRED: HIP	A Patient Authorization	
Print Patient or Caregiv	er Name:	Relationship to Patient:
O I have read and agre	ee to the HIPAA Patient Authorization	included on page 5 (required)

PAT		
E/A II		SIN

PATIENT SIGNATURE HERE

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 <u>www.fda.gov/medwatch</u> or call **1-800-FDA-1088**.

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GSK Oncology	(dostarlimab-gxly) Injection 500 mg				Page 4 of 5
			Visit us	at www.Togethe	rwithGSKOncology.com
Patient Name:			•	n: / / _	
7 Prescriber/Facility			_		
		Due e suite su Titl		Que a si altera	
	DEA #:				
	NPI #:				
8 Co-pay Program E	lectronic Funds Transfer (EFT) Opt-in	(Optional)			
provider on behalf of eligi provider enrollment in EF	mail below if you would like the Together w ble enrolled patients for patients' eligible c T and patient eligibility for the JEMPERLI C	co-pay via direc Co-pay Progran	et deposit. Disbui n.	rsement of paym	nent is subject to full
9 Preferred Shipping	Location				
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	City:				ZIP:
Site of Administration:	O Physician's office O Hospital outperformance		Another site of ca	lre	
10 Clinical Informatio	n				
Diagnosis ICD-10 Code	O C54.1-Malignant neoplasm of endo	metrium	Other:		
Mismatch repair status		Endometria	al cancer prior t	herapies: (checl	< all that apply)
O Mismatch repair deficie	ent (dMMR)		t with platinum-c		
O Mismatch repair profici		Other:	•	0.0	
PRESCRIPTION:					
MEDICATION	STRENGTH/FORM	D	IRECTIONS FO	R ADMINISTRA	TION
O JEMPERLI IV	Injection: clear to slightly opalescent, co to yellow solution supplied in a carton containing one 500 mg/10 mL (50 mg/r single-dose vial (NDC 0173-0898-03)	colorless • /mL),	Dose 1 through Subsequent dos (Dose 5 onwards	4: 500 mg every sing beginning 3 s): 1000 mg ever	3 weeks. weeks after Dose 4
1 REQUIRED: Prescr	iher Declaration				
that, for any insured patie program, any applicable of treatment. I appoint Toge permitted under state law states with official prescri	on provided above is true and that JEMPEI ent seeking co-pay assistance under the Co co-pay, coinsurance, or other out-of-pocke ther with GSK Oncology, on my behalf, to o v. Special Note: Prescribers in all states mu ption form requirements, please submit an onic prescription to the specialty pharmacy.	o-pay Program et cost for JEM convey this pre ust follow applic n actual prescrip	, in the absence PERLI would be escription to the o cable laws for a v	of financial supp collected from th dispensing pharr /alid prescription	port from such ne patient upon nacy, to the extent n. For prescribers in

NO STAMPS PLEASE

____ Date: ____ / ____ / ____

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Together with GSK Oncology

GSK



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Visit us at www.TogetherwithGSKOncology.com

REQUIRED: HIPAA Patient Authorization

By signing this form on page 3, **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 its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing Together with GSK Oncology services, which may include the following activities:

- 1. Communicating with my Healthcare Providers about my BLENREP prescription and medical condition;
- 2. Providing ophthalmology support, including ophthalmologist referral information and appointment reminders;
- 3. Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for GSK's patient assistance and co-pay assistance programs;
- 4. 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;
- 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, or 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 Together with GSK Oncology 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 Together with GSK Oncology, P.O. Box 5490, Louisville, KY 40255, but
 such a revocation would end my eligibility to participate in the Together with GSK Oncology
 program. Revoking this authorization will prohibit further disclosures by my Healthcare
 Providers based on this authorization after the date a 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.

The patient, or the patient's authorized representative, **MUST** sign this form (section 6) in order for the patient to receive Together with GSK Oncology services. If an authorized representative signs for the patient, please indicate relationship to the patient.

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