Together with GSK Oncology Enrollment Form

Fax completed enrollment form to 1-800-645-9043
For assistance, please call 1-844-4GSK-ONC
Monday-Friday (8 AM to 8 PM ET)

Together with GSK Oncology

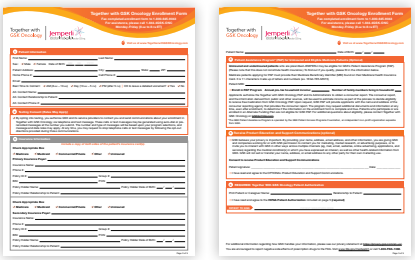
Jemperli (dostarlimab-gxly) Injection 500 mg

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 10 on page 4.
Fax the completed and signed enrollment form, plus copies of your patient's medical and pharmacy insurance cards, to 1-800-645-9043.

Patient Information (see pages 2 and 3)



Section 1: Complete the Patient Information.

Section 2 (optional – for eligible copay patients only): If you'd like to receive communications about your copay enrollment via text message, check the box to enroll.

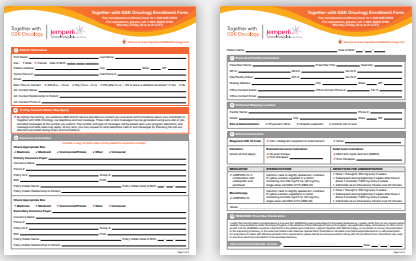
Section 4 (optional): If you'd like to see if you're eligible for GSK's Patient Assistance Program (PAP), check the box to enroll, complete PAP information to research eligibility.

Section 5 (optional): Please complete this section if you'd like to opt into the Patient Support Program.

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 copay assistance options for eligible patients.

Prescriber Information (see pages 2 and 4)



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: Identify preferred shipping location if different than section 7.

Section 9: Clinical information is very important and often requested when verifying benefits. Diagnosis and appropriate ICD-10 code are required fields.

Section 10: 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 Copay Assistance**
- **Alternate Coverage Options**
  - Information About Patient Advocacy Organizations
  - Information About Independent Copay Foundations

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1 Patient Information

First Name: _____ Last Name: _____

Sex: ❍ Male ❍ Female Date of Birth: MM DD YYYY

Patient Address: _____ City: _____ State: _____ ZIP: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Best Time to Contact: ❍ AM (8 AM – 10 AM) ❍ Day (10 AM – 5 PM) ❍ PM (after 5 PM) | OK to leave a detailed voicemail? ❍ Yes ❍ No

Alt. Contact Name: _____

Alt. Contact Relationship to Patient: _____

Alt. Contact Phone #: _____

2 Texting Consent (Rates May Apply)

❍ By opting into texting, you authorize GSK and its service providers to contact you and send communications about your enrollment in Together with GSK Oncology 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.

3 Insurance Information

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

Check Appropriate Box

❍ **Medicare** ❍ **Medicaid** ❍ **Commercial/Private** ❍ **Other** ❍ **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

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

Secondary Insurance Payer: _____

Insurance Name: _____

Phone #: _____

Policy ID #: _____ Group #: _____

BIN: _____ PCN: _____

Policy Holder Name: _____ Policy Holder Date of Birth: ____ / ____ / _____

Policy Holder Relationship to Patient: _____

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Patient Name: _____ Date of Birth: ____ / ____ / _____

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

Uninsured and underinsured patients who are prescribed JEMPERLI 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 PAP must provide their Medicare Beneficiary Identifier (MBI) found on their Medicare Health Insurance Card. It is 11 characters made up of letters and numbers (ex. 1EG4-TE5-MK73)

Patient MBI: _____

❍ **Enroll in PAP Program** **Annual pre-tax household income:** _____ **Number of family members living in household:** ____

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. Patients who participate or are enrolled in an Alternate Funding Plan are not eligible for GSK PAP. For additional questions about eligibility, please contact Together with GSK Oncology 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.

5 Receive Product Education and Support Communications (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.

Consent to receive Product Education and Support Communications

Patient signature: _____ Date: _____

❍ I have read and agree to the OPTIONAL Product Education and Support Communications.

6 REQUIRED: Together With GSK Oncology Patient Authorization

Print Patient or Caregiver Name: _____ Relationship to Patient: _____

❍ I have read and agree to the **HIPAA Patient Authorization** included on page 5 **(required)**

PATIENT TO SIGN _____ 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 www.fda.gov/medwatch or call **1-800-FDA-1088**.

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Patient Name: _____ Date of Birth: ____ / ____ / _____

7 Prescriber/Facility Information

Prescriber Name: _____ Prescriber Title: _____ Specialty: _____

NPI #: _____ DEA #: _____ Tax ID #: _____

Site/Facility Name: _____ NPI #: _____ Tax ID #: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Office Contact Name: _____ Office Contact Phone #: _____ Fax #: _____

Office Contact Email: _____

8 Preferred Shipping Location

Facility Name: _____ Phone #: _____

Street: _____ City: _____ State: _____ ZIP: _____

Site of Administration: ❍ Physician's office ❍ Hospital outpatient ❍ Another site of care

9 Clinical Information

Diagnosis ICD-10 Code	❍ C54.1-Malignant neoplasm of endometrium	❍ Other: _____
Indication (check all that apply)	**Endometrial cancer indication:** ❍ No prior therapy ❍ Prior therapies: _____	**Solid tumor indication:** ❍ Mismatch repair deficient (dMMR) ❍ Prior therapies: _____

MEDICATION	STRENGTH/FORM	DIRECTIONS FOR ADMINISTRATION
❍ JEMPERLI IV in combination with carboplatin and paclitaxel	Injection: clear to slightly opalescent, colorless to yellow solution supplied in a carton containing one 500 mg/10 mL (50 mg/mL), single-dose vial (NDC 0173-0898-03)	• Dose 1 through 6: 500 mg every 3 weeks. • Subsequent dosing beginning 3 weeks after Dose 6 (Dose 7 onwards): 1000 mg every 6 weeks. • Administer as an intravenous infusion over 30 minutes.
Monotherapy ❍ JEMPERLI IV	Injection: clear to slightly opalescent, colorless to yellow solution supplied in a carton containing one 500 mg/10 mL (50 mg/mL), single-dose vial (NDC 0173-0898-03)	• Dose 1 through 4: 500 mg every 3 weeks. • Subsequent dosing beginning 3 weeks after Dose 4 (Dose 5 onwards): 1000 mg every 6 weeks. • Administer as an intravenous infusion over 30 minutes.

Notes: _____

10 REQUIRED: Prescriber Declaration

I certify that the information provided above is true and that JEMPERLI 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 JEMPERLI 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.

HEALTHCARE PROFESSIONAL TO SIGN _____ NO STAMPS PLEASE Date: ____ / ____ / _____

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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 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 Together with GSK Oncology services or Patient Assistance Programs, which may include the following activities:

1. Communicating with my Healthcare Providers about my JEMPERLI 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.

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 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 **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 and the GSK Patient Assistance 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 or Patient Assistance Program services. If an authorized representative signs for the patient, please indicate relationship to the patient.

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GSK