Enrollment Form for Patient Reimbursement Support Program for ZEJULA

Fax completed enrollment form to 1-800-645-9043

Please see the instructions guide on page 4 for a quick reference on how to fill out this form and enroll your patient in the Patient Reimbursement Support Program for ZEJULA.

Check for services requested:

❍ Coverage Support (Benefits Investigation, Prior Authorization, and/or Appeals Support)
❍ Co-pay Assistance
❍ Patient Assistance Program
❍ Referral to Other Support Services (eg, patient advocacy organizations, peer to peer support, and non–co-pay support)

1 Prescriber/Facility Information

Prescriber's Name: ______________________

Prescriber's Title: ______________ Specialty: ______________

NPI #: ______________ DEA #: ______________

Tax ID #: ______________________

Site/Facility Name: ______________________

Mailing Address: ______________________

City: ______________ State: ________ ZIP: ________

Office Contact's Name: ______________________

Office Contact's Phone #: ______________ Fax #: ______________

Office Contact's Email: ______________________

Preferred Method of Contact: ❍ Phone ❍ Email

2 Patient Information

Patient's Name: ______________________

Sex: ❍ Male ❍ Female Date of Birth: ______ / ______ / __________

Patient's Address: ______________________

City: ______________ State: ________ ZIP: ________

Home Phone #: ______________ Cell Phone #: ______________

Email: ______________________

Best Time to Contact:
❍ AM (8 AM to 10 AM) ❍ Day (10 AM to 5 PM) ❍ PM (after 5 PM)

Alt. Contact's Name: ______________________

Alt. Contact's Relationship to Patient: ______________________

Alt. Contact's Phone #: ______________________

3 Clinical Information

Treatment Target Start Date: ______ / ______ / __________

Primary Diagnosis: ______________________ Primary Diagnosis ICD-10 Code: ______________

Secondary Diagnosis: ______________________ Secondary Diagnosis ICD-10 Code: ______________

***BRCA* Test:** ❍ Positive ❍ Negative ❍ Results Pending ❍ No Test

Recurrent ovarian cancer in complete or partial response to platinum-based chemotherapy: ❍ Yes ❍ No

Known Drug Allergies: ______________________

Notes:

4 Insurance Information (check the relevant box)

Attach a copy of both sides of the patient's insurance card.

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

Primary Insurance Payer: ______________________

Insurance Name: ______________________

Phone #: ______________________

Policy ID #: ______________ Group #: ______________

BIN: ______________ PCN: ______________

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______ / ______ / __________

Policy Holder's Relationship to Patient: ______________________

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

Prescription Insurance Payer: ______________________

Insurance Name: ______________________

Phone #: ______________________

Policy ID #: ______________ Group #: ______________

BIN: ______________ PCN: ______________

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______ / ______ / __________

Policy Holder's Relationship to Patient: ______________________

5 Preferred Specialty Pharmacy (select one)

Preferred Specialty Pharmacy selection will be honored if permitted by patient's insurance plan.

❍ No preference ❍ US Bioservices ❍ Diplomat Pharmacy, Inc. ❍ Biologics, Inc. ❍ In-office dispensing site

Call us at 1-844-283-7276, Monday-Friday (8 AM to 8 PM ET)

Fax us the completed enrollment form at 1-800-645-9043

Email us at info@tesaroforyou.com

Visit us at www.TOGETHERwithTESARO.com

Enrollment Form for Patient Reimbursement Support Program for ZEJULA

Fax completed enrollment form to 1-800-645-9043

6 Preferred Shipping Location (check one if shipping is needed)

❍ Patient's Address (address from Section 2)

❍ Other Address (eg, provider office, infusion center):

Facility Name: ______________________ Phone #: ________________

Recipient Name: ____

Street: ____

City: ______________________________State: _______ ZIP: ________

Prescription Information/Prescriber Declaration

7 Prescription Information

Patient's Name: ____ Patient's Date of Birth: _____ / _____ / __________

Rx for ZEJULA® (niraparib) **Quantity:** ______ **Refills:** __ **Treatment Target Start Date:** _____ / _____ / __________

Directions for Use: Take ______ (100-mg) capsules by mouth, with or without food, once daily, at the same time each day (preferably in the evening).

Other Directions: ____

Prescriber Declaration: I certify that the information provided above is true and that ZEJULA 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 ZEJULA would be collected from the patient upon treatment. I appoint the Patient Reimbursement Support Program for ZEJULA, 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.

With my signature, I authorize TESARO, Inc. and GlaxoSmithKline (GSK) and the specialty pharmacy to dispense ZEJULA directly to the patient.

Prescriber's Name (Please print): ____

Prescriber's Signature (No stamps please): ______________________________ Date: _____ / _____ / __________

Please attach a separate prescription if this section does not comply with your state's prescription law. ***Prescriptions from New York must be issued electronically.***

The prescribed quantity of ZEJULA will be shipped to the address indicated in Section 6 above.

8 Patient Financial Information (required for Patient Assistance Program)

Please note, eligibility for the PAP is based on the Federal Poverty Level and may change year to year.

Income will be verified using data from Experian Health. In cases where income cannot be verified, or there are discrepancies, additional proof of income may be required.

Annual Gross Household Income: $______________________ **# of Household Members (Including patient):** __________________

9 HIPAA Patient Authorization (patient signature required)

By my signature, I agree to the uses and disclosures of my health information described on the attached **HIPAA patient authorization.** The patient, or the patient's authorized representative, MUST sign this in order for the patient to receive services through the Patient Reimbursement Support Program for ZEJULA. If an authorized representative signs for the patient, please indicate relationship to the patient.

Patient Name or Caregiver Name (Please print): ______________________________ **Date:** _____ /_____ /_______

Relationship to Patient: ____

Patient or Caregiver's Signature: ____

Enrollment Form for Patient Reimbursement Support Program for ZEJULA

Fax completed enrollment form to 1-800-645-9043

10 Optional Patient Services and Support

TESARO, GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") offer helpful services and resources to support you on your treatment journey with ZEJULA.

TESARO, GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") believe your privacy is important. By providing your name, address, phone number, email address, and other information, you are giving TESARO, GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") permission to market or advertise to you 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 TESARO and GSK. TESARO, GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") will not sell or transfer your name, address, or email address to any other party for their own marketing use. For additional information regarding how TESARO and GSK handle your information, please see our privacy statement: https://privacy.gsk.com/en-us/pharmaceuticals/default/.

I have read and agree to receive optional patient services and support.

Patient Signature: ______________________________ **Date:** _____ /_____ /_______

HIPAA Patient Authorization

By my signature, 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 TESARO, GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that TESARO and GSK can use and disclose my health information for purposes of providing services for the Patient Reimbursement Support Program for ZEJULA, which may include the following activities:

- Communicating with my Healthcare Providers about my ZEJULA prescription and medical condition;
- Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for TESARO and GSK's patient assistance and co-pay assistance programs;
- 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;
- 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 TESARO and GSK for disclosing my information to TESARO and GSK as permitted by this authorization.
- Once information about me is released to TESARO and GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent TESARO and GSK from further disclosing my information. However, I understand that TESARO and GSK have 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 Patient Reimbursement Support Program for ZEJULA, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to PO Box 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in the Patient Reimbursement Support Program for ZEJULA. 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 TESARO and GSK prior to the revocation may be disclosed within TESARO and GSK to maintain records of my participation.

Enrollment Form for Patient Reimbursement Support Program for ZEJULA

Fax completed enrollment form to 1-800-645-9043

Instructions:

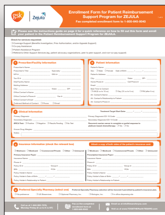
Complete the first 3 pages of this form.

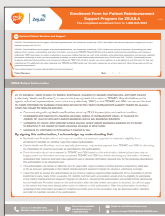
Healthcare Professional to sign and date Section 7 on page 2.

Patient to sign and date Section 9 on page 2.

Fax completed enrollment form to 1-800-645-9043.

ZEJULA Enrollment Form





Select services requested to specify the needs of your patient.

Sections 1 and 2: Prescriber and Patient contact information is required in this section. Be sure to include NPI and DEA numbers to help facilitate the Benefits Investigation.

Section 3: Clinical information requested is very important and often requested when verifying benefits. Diagnosis and appropriate ICD-10 code are required fields. Including clinic notes and/or supporting evidence of *BRCA* testing with this fax is optional.

Section 4: Be sure to fill out the patient's insurance information. In addition, a copy of both sides of the patient's insurance cards can be included at your discretion.

Section 5: Select your preferred specialty pharmacy. If your preferred specialty pharmacy is not in TESARO and GSK's limited distribution network or honored by the patient's insurance plan, the benefits investigation will inform you of the approved specialty pharmacy options available for your patient.

Section 6: ZEJULA will be delivered to the patient's home unless otherwise requested in this section.

Section 7: This section can serve as the prescription for ZEJULA for commercial patients and requires prescriber signature.

Section 8: Be sure to fill out Patient Financial Information if enrollment in the patient assistance program is requested.

Section 9: HIPAA Patient Authorization: Patient signature on authorization form is required.

Section 10: Optional Patient Services and Support Consent for ZEJULA.

Suite of Solutions:

- Benefits Investigation
- Prior Authorization Facilitation and Appeals Support
- Quick Start and Bridge Programs
- Commercial Co-pay Assistance Program
- Referrals to Patient Advocacy Organizations
- Referrals to Independent Co-pay Foundations
- Patient Assistance Program (PAP)

Call us at 1-844-283-7276, Monday-Friday (8 AM to 8 PM ET)

Fax us the completed enrollment form at 1-800-645-9043

Email us at info@tesaroforyou.com

Visit us at www.TOGETHERwithTESARO.com

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

©2019 GSK or licensor.
NRPPSP190004 October 2019
Produced in USA. 0002-0003-60