Together with GSK Enrollment Form

Fax completed enrollment form to 1-844-715-0964
For assistance, please call 1-8-HIBSAGO-11 (1-844-272-4611)
Monday–Friday, 8 AM–8 PM ET

together with | HIBSAGO (bepirovirsen) Subcutaneous Use 150 mg/mL

Visit us at www.TogetherwithGSK.com

An electronic enrollment form is available online. Scan the QR code to access Together with GSK.

Program services include:

- Coverage Support
- Patient Assistance Program (PAP)*
- Copay Assistance Program
- Disease State and Product Education
- Lab Coordination
- Bridge Program

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

***Indicates required fields**

Patient Information

First name*:		Last name*:
Street*:		City*:
State*:	Zip*:	Email*:
Date of birth (mm/dd/yyyy)*:	Gender:	Language preference (if other than English):
Preferred phone #*: ☐ Home ☐ Mobile		Alternate contact name:
OK to leave a detailed voicemail? ☐ Yes ☐ No		Alternate contact phone #: ☐ Home ☐ Mobile
Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening		Alternate contact relationship to patient:

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

☐ No insurance	Pharmacy/Prescription insurance	Primary medical insurance
Insurance provider:		
Insurance phone:		
Cardholder name (if not the patient):		
Cardholder date of birth:		
Policy #:		
Group #:		
BIN/PCN:		N/A

Is a prior authorization on file with the payer? ☐ Yes ☐ No	If "Yes," authorization #:	Expiration date:
Print name:	Relationship to patient:	
PATIENT TO SIGN — PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE REQUIRED HERE		Date:
I have read and agree to the HIPAA Patient Authorization Form (please see page 5).*		
PATIENT TO SIGN — PATIENT SIGNATURE HERE		Date:
I have read and agree to the Marketing Opt-in Consent included on page 2 (optional).		

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Patient name: _____ Date of birth (mm/dd/yyyy): _____

*Indicates required fields

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

Uninsured and underinsured patients who are prescribed HIBSAGO may be eligible for GSK's 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 the PAP must provide their Medicare Beneficiary Identifier (MBI) found on their government-issued Medicare health insurance card. It is 11 characters made up of letters and numbers (eg, 1EG4-TE5-MK73).

MBI: _____

☐ Enroll in PAP

Annual pre-tax household income: _____ Number of family members living in household: _____

Applicants authorize the GSK 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 PAP. Upon request, the 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 Program are not eligible for the GSK PAP. For additional questions about eligibility, please contact the program or GSKPAF.org.

*The GSK PAP is operated by the GSK Patient Access Programs Foundation, an independent non-profit organization separate from GSK.

Marketing Opt-In (Optional)

GSK offers helpful services and resources that help you begin and continue treatment with HIBSAGO. GSK believes your privacy is important. By providing your name, address, email address, and other information 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.

For additional information regarding how GSK handles your information, please see our privacy notice 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.

Patient email address: _____

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Patient name: _____ Date of birth (mm/dd/yyyy): _____

***Indicates required fields**

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

Prescriber's first name*:	Prescriber's last name*:		
Practice name*:	Specialty:		
Street*:	City*:	State*:	Zip*:
Office contact name*:	HCP communication preference*: ☐ Email ☐ Phone		
Email:	Phone*: Ext:	Fax*:	
Prescriber NPI #*:	State license #:		

Preferred Shipping Location

Select where product should be shipped: ☐ Patient's address ☐ Prescriber's office address

If preferred shipping location differs from patient or prescriber office addresses, please provide address where product should be shipped below.

Provider location name:		Street:	
City:	State:	Zip:	Phone:

***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.

Chronic Hepatitis B Virus (HBV) Infection	☐	B18.1	Chronic viral hepatitis B without delta-agent
Other ICD-10-CM code	☐		

	LAB TEST	RESULTS	DATE OF TEST
Lab Testing Status†	Quantitative hepatitis B surface antigen (HBsAg)		
	Qualitative hepatitis B surface antigen (HBsAg)		
	Hepatitis B virus deoxyribonucleic acid (HBV DNA)		
	Alanine aminotransferase (ALT)		
	Aspartate aminotransferase (AST)		
	Bilirubin		
	Platelet count		
	Urine albumin-creatinine ratio (uACR)		
	Estimated glomerular filtration rate (eGFR)		

†Please attach copies of all relevant laboratory test results.

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*Indicates required fields

Prescriber, Acquisition, and Administration Information (cont.)

Patient name*:	**Date of birth (mm/dd/yyyy)*:**
• Prescriber signature below is required for Rx and/or enrollment • Specialty pharmacy selection is subject to health plan requirements	
Has the patient previously received HIBSAGO? ☐ Yes ☐ No	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? ☐ PANTHERx ☐ Other	

Prescription: Prescriber to indicate preferred dosing regimen of HIBSAGO.

		DOSAGE (STRENGTH AND FORM)	QTY	REFILLS	DIRECTIONS FOR ADMINISTRATION
HIBSAGO 150 mg/ml solution single-dose pre-filled syringe in cartons of 2 (NDC 0173-0941-39)	☐	Weeks 1 to 4 **300 mg** (Two **150 mg/ml** solution in single-dose pre-filled syringes)	6 cartons	0	**Chronic HBV Infection:** Weeks 1 and 2 300 mg subcutaneously to upper arm, thigh, or abdomen **twice** a week allowing 3 or 4 days between each dose Weeks 3 to 24 300 mg subcutaneously to upper arm, thigh, or abdomen **once** a week
	☐	Weeks 5 to 24 **300 mg** (Two **150 mg/ml** solution in single-dose pre-filled syringes)	4 cartons	☐ 4 refills or ___ refills	

Bridge Program: Prescriber to indicate preferred dosing regimen of HIBSAGO.

☐ Yes, I would like to participate in the HIBSAGO Bridge Program.

		DOSAGE (STRENGTH AND FORM)	QTY	REFILLS	DIRECTIONS FOR ADMINISTRATION
HIBSAGO 150 mg/ml solution single-dose pre-filled syringe in cartons of 2 (NDC 0173-0941-39)	☐	**300 mg** (Two **150 mg/ml** solution in single-dose pre-filled syringes)		☐ 4 refills or ___ refills	**Chronic HBV Infection:** Weeks 1 and 2 300 mg subcutaneously to upper arm, thigh, or abdomen **twice** a week allowing 3 or 4 days between each dose Weeks 3 to 24 300 mg subcutaneously to upper arm, thigh, or abdomen **once** a week

Allergies:	Concurrent therapy:

Prescriber Declaration: I certify that the information provided above is true and that HIBSAGO is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the GSK Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for HIBSAGO would be collected from the patient upon treatment. I appoint the Together with GSK program, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law.

HIBSAGO Bridge Program provides free product for eligible commercially insured patients who have received at least one dose but are experiencing coverage interruption in accordance with program rules and when other program eligibility criteria have been satisfied. I certify that I will not seek reimbursement for any free product provided under this program. The products supplied through the HIBSAGO Bridge Program are intended solely for the named, prescribed patient. If the patient subsequently secures commercial insurance and receives product through that coverage, or the interruption of coverage is resolved, the patient would no longer receive product through the Bridge Program.

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 PANTHERx specialty pharmacy.

PRESCRIBER TO SIGN	PRESCRIBER SIGNATURE REQUIRED HERE	
	DISPENSE AS WRITTEN (brand medically necessary)*	**(Date)**

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

By signing this form, **I authorize** my doctors; pharmacies, including my Specialty Pharmacy(ies); alternate site of care; and health insurers (collectively, my "Healthcare Providers") to use and disclose my personal health information (my "Information") to GlaxoSmithKline and to the GSK Patient Access Programs Foundation and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and share my Information for purposes of providing Together with GSK services or Patient Assistance Programs, which may include the following activities:

1) Communicating with my Healthcare Providers about my medication 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) Disclosing my information to third parties if required by law;
5) Sending me educational information about my medication and contacting me to describe (and, if I am interested, to provide) optional educational services offered by healthcare professionals; and
6) If I sign the Together with GSK Support Consent on page 1 of this form, sending me promotional information as described in the Together with GSK Support Consent paragraph on page 2 of this form.

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

- My Healthcare Providers may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on my signing 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 my Information is released to GSK based on this authorization, federal privacy laws may no longer protect the Information from re-disclosure. However, I also understand that GSK intends to share my Information only as described in this authorization or as otherwise permitted by law.
- This authorization will remain in effect for two (2) years after I sign it or for as long as I participate in the **Together with GSK** or the GSK Patient Assistance Program, whichever is longer, subject to any applicable state law requirement for the authorization to expire.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to PANTHERx Rare Pharmacy, 121 Bayer Rd. Building 5, Pittsburgh, PA 15205. Such a revocation will invalidate reliance on the authorization to use or disclose my Information, but will not invalidate any uses or disclosures made prior to the date my written statement of revocation is received. I understand that, even if I revoke the authorization, GSK may maintain my Information as part of records of my participation in the Together with GSK and GSK Patient Assistance Program.
- I understand that I, as the patient or a legal representative signing on behalf of the patient, 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 Together with GSK or GSK Patient Assistance Program services. If an authorized representative signs for the patient, please indicate relationship to the patient.

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