Oxbryta™ (voxelotor) 500 mg tablets
PATIENT ENROLLMENT FORM

Phone: (833)-GBT-4YOU (833-428-4968) Fax: (888) 418-4178

Global Blood Therapeutics (GBT) Source Solutions is a resource for your patients and your office that offers access and reimbursement support after Oxbryta has been prescribed. We're committed to helping your patients start and stay on Oxbryta as prescribed.

FOR HEALTHCARE PROVIDERS ONLY: ABOUT THIS FORM

Completing this form and enrolling in the GBT Source program, will allow GBT Source to:

- Review your patient's insurance coverage through a Benefit Verification call with the payer
- Determine payer guidelines for obtaining Oxbryta, such as a Prior Authorization
- Review potential financial assistance programs available for your patient, including co-pay and out-of-pocket expenses
- Provide education on the Specialty Pharmacy triage process and the network that will dispense Oxbryta
- Coordinate shipments directly with your patient's pharmacy
- Provide educational resources and support to help continue with Oxbryta as prescribed
- Access marketing materials from GBT and GBT Source on Oxbryta (optional)

THE GBT SOURCE CARE TEAM IS AVAILABLE TO ASSIST

GBT Source is here to assist you and your patients. Our committed Care Team includes:

- **Care Coordinators** who are available for your patients by phone to discuss insurance benefits and review financial assistance programs for eligible patients prescribed Oxbryta
- A **Nurse Support*** team who can provide educational resources and answer questions for patients who are taking Oxbryta
- **Patient Navigators** who can assist your practice with onsite, in-person support, providing information on GBT Source resources and help with navigating insurance and access requirements for Oxbryta

*The Nurse Support team is there to support product adherence, and not replace a patient's treatment plan. They do not provide medical advice or case management services.

INSTRUCTIONS FOR HEALTHCARE PROVIDERS:

1. Complete **ALL FIELDS** of this Patient Enrollment form.
2. Remember to **SIGN AND DATE** the form in the appropriate boxes. The signed enrollment form is the Oxbryta prescription.
3. You can use the GBT Source Portal to complete and submit the enrollment form to enroll patients. Go to hcp.GBTsource.com. Or you can fax this completed form to: (888) 418-4178. (If you need additional enrollment forms, you can download them at EnrollOxbryta.com).
4. Your patient must complete and sign the Patient Authorization form to receive support from GBT Source Solutions. There are 2 ways to obtain patient consent:
   a. Have the patient complete and sign the form in your office and submit it along with the healthcare provider portion of the form (this is the preferred method)
   b. Email a link to the Patient Authorization form to your patient (you are able to email the link if you enroll the patient through the GBT Source Portal)

   If you are unable to obtain a completed and signed Patient Authorization form in one of these ways, GBT Source will attempt to contact the patient on receipt of your signed healthcare provider prescription enrollment form.
5. Completed forms will be sent to a participating Specialty Pharmacy.
6. A GBT Source Care Coordinator is available to assist with completing this enrollment form.

If you have any questions about completing this form, please call GBT Source at (833) GBT-4YOU (833-428-4968), M-F 8am-8pm ET

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Step 1: Patient Information

First Name	MI	Last Name
Address		Apt #
City	State	ZIP
DOB (mm/dd/yyyy)	Gender ☐ Male ☐ Female	

Patient Home Phone #	Patient Email Address	Patient Cell Phone #

Authorized Caregiver or Alternative Contact

Name of Authorized Caregiver	Relationship to Patient	Alternative Contact Phone #	Alternative Contact Email Address

Step 2: Insurance Information

Fax a copy of front and back of patient's medical and prescription benefit insurance cards, or fill in the information below.

Has the patient started therapy ☐ Yes ☐ No	Is the patient insured? ☐ Yes ☐ No

Is the patient's prescription paid for in whole or in part by a Government-funded program such as Medicaid, Medicare, Medicare Part D, Tricare, VA, or DOD? ☐ Yes ☐ No

Prescription Benefit Insurance

Insurance Name	Policy ID #	Group #
Phone #	PCN #	BIN #
Policy Holder Name	DOB	Relationship to Patient

Medical/Health Insurance

Insurance Name	Phone #	Policy ID #	Group #
Policy Holder Name		DOB	Relationship to Patient

Secondary Insurance

Insurance Name	Phone #	Policy ID #	Group #

Step 3: Prescriber Information

Prescriber First Name	Last Name	MD Specialty

Practice Information

Practice/Office Name		
Address		Suite #
City	State	ZIP
Office Phone #	Office Fax #	
MD NPI #	Tax ID #	State License #
Office Contact	Office Contact Phone #	Office Contact Email

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Patient Name: ______________________ DOB ______________

Step 4: Diagnosis and Clinical Information

Patient ICD-10 Diagnosis	Other

Current therapies

Step 5: Prescription Information Oxbryta 500 mg/tab

Dose: **Oxbryta 500 mg tablets**

Quantity: **90 Count bottle**

NDC # **72786-0101-01**

Directions (SIG): ☐ Take 3 tablets, by mouth, once daily ☐ Other:

Refills Authorized:

Step 6: Physician Certification and Signature

By signing below I certify that:

1. I am prescribing the Oxbryta medication for the patient identified above. I certify that this prescription is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatment.
2. The information provided on this enrollment form was completed by me or at my direction. The information contained herein is complete and accurate to the best of my knowledge. I have discussed GBT Source Patient Solutions with my patient and informed him/her of the resources available and have confirmed my patient's wishes to enroll.
3. I have received all necessary authorizations and consents from the patient, and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state laws, needed to release the above information to GBT, GBT Source Patient Solutions, and their contractors, agents, representatives, agents and assignees, as well as the patient's insurance company or pharmacy for the purposes described herein.
4. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. I understand that noncompliance with state-specific requirements could result in outreach to me by the pharmacy.
5. I understand that the information provided herein will be used for purposes of providing GBT Source Patient Solutions, including investigating and verifying the patient's insurance coverage benefits for Oxbryta, coordination of the dispensing and delivery of Oxbryta, assisting in initiating or continuing therapy, providing prior authorization and appeals information, as well as a co-pay program and co-pay assistance foundation referrals, providing me and my patient with other education and support associated with Oxbryta, evaluating the effectiveness of Oxbryta, and for GBT internal business purposes.
6. I agree that I shall not seek reimbursement for any GBT medication dispensed to the patient through the Patient Assistance Program, from any government program or third-party insurer.
7. I authorize the above prescription to be forwarded to the pharmacy chosen by the named patient. I understand that I must comply with my state specific prescription requirements such as e-prescribing, state specific Prescription form, fax language, etc.

Prescriber Signature:

______________________ ______________________

(Dispense as Written/Do Not Substitute) (Substitution Permitted)

Date: ______________________

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PATIENT AUTHORIZATION AND CONSENT FORM

Phone: (833)-GBT-4YOU (833-428-4968)   Fax: (888) 418-4178

Global Blood Therapeutics (GBT) Source Solutions offers support and resources to help you start and stay on treatment with Oxbryta as prescribed by your treating physician.

FOR PATIENTS: ABOUT THIS FORM

Upon completing and signing the Patient Authorization Form, you will be automatically enrolled in the GBT Source Solutions program. GBT Source can provide the following assistance:

- Review your insurance coverage through a Benefits Verification call with your health insurance provider
- Work with your Doctor/Healthcare Provider to inform him/her of your insurance coverage
- Review financial assistance programs for which you may be eligible that may help with your co-pay
- Coordinate shipments of Oxbryta through your Specialty Pharmacy
- Provide education resources and support to help start and stay on Oxbryta as prescribed
- Access to marketing materials from GBT and GBT Source on Oxbryta (requires patient opt-in and consent)
- Communicate via text with you about your prescribed Oxbryta (requires patient opt-in and consent)

THE GBT SOURCE CARE TEAM IS AVAILABLE TO ASSIST

Our committed Care Team includes:

- **Care Coordinators** who will contact you to discuss your insurance benefits and review financial assistance programs for which you may be eligible
- A **Nurse Support*** team who can answer questions you may have about your prescribed Oxbryta and help you start and stay on treatment

*The Nurse Support team is there to support product adherence, and not replace a patient's treatment plan. They do not provide medical advice or case management services.

INSTRUCTIONS FOR PATIENTS

Please follow these 3 steps to enroll and get started with GBT Source Solutions:

1. Read the Patient Authorization and Consent form
2. Sign and date the form. Please note that a signed and dated form is required to enroll and receive GBT Source support offerings
3. Submit your completed and signed form. There are 3 ways you can do this:
   a. Fax it to (888) 418-4178
   b. Mail it to GBT Source, 680 Century Point, Lake Mary, Florida, 32746
   c. Contact GBT Source, and they will email or text a link that will allow you to access the form electronically

A Care Coordinator from GBT Source will contact you and/or your doctor's office to provide information about your insurance coverage and available program resources.

If you have any questions about this form or need help with its completion, please contact your healthcare provider or call GBT Source at (833) GBT-4YOU (833-428-4968), M-F 8am-8pm ET

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Patient Name (Required) ______________________________

By signing this form, I hereby direct and authorize Global Blood Therapeutics (GBT), GBT Source Solutions and their contractors, agents, representatives, agents and assignees, and my physicians, pharmacies and health plan(s) (collectively, the “Entities”) to disclose, use, and share my Personal Information (as defined herein) to provide the GBT Source Solutions described herein.

I authorize my personally identifiable health and demographic information to be shared with GBT Source Solutions described herein, including my full name, address, birth date, telephone number and email address, information about my medical condition, information about my health benefits and health insurance coverage, financial information, as necessary, and any other information collected in the enrollment form (collectively, “Personal Information”).

I authorize the Entities to disclose, use, and share my Personal Information for the purpose of facilitating my access to GBT Source Patient Solutions program, including to:

- Investigate and verify my insurance coverage benefits for Oxbryta,
- Coordinate the dispensing and delivery of Oxbryta,
- Assist in initiating or continuing on therapy,
- Provide prior authorization and appeals support
- Facilitate enrollment into a co-pay assistance program and/or provide referrals to Foundations for co-pay assistance,
- Provide education and support associated with Oxbryta, and
- Evaluate the effectiveness of Oxbryta and help advance GBT’s internal business objectives, including quality control and assessment.

Once I sign this Patient Consent Form and my Personal Information is released, I understand that the Health Insurance Portability and Accountability Act (“HIPAA”) may no longer protect or prohibit the redisclosure of the Personal Information disclosed.

I understand that I can choose not to sign this form and that my health care providers and health plan may not condition either my treatment or my payment, enrollment or eligibility for benefits on signing this form; however, I will not be able to enroll in the GBT Source Solutions program without it.

This form is valid for five (5) years from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law.

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Patient Name (Required) ______________________________

I have the right to cancel this authorization. If I cancel, this means that the Entities will no longer share my Personal Information as described herein, but this will not apply to Personal Information already used or shared or when it is required by law. To cancel, I must send a written notice to GBT. It can be sent by fax to (888) 418-4178 or by mail to GBT Source, 680 Century Point, Lake Mary, Florida, 32746.

If I cancel, I know that I will no longer be able to receive GBT Source Solutions assistance.

I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid.

By signing below, I authorize the use and disclosure of my Personal Information in the ways described in this form.

Patient/Authorized Representative

Signature (Required): ______________________ Date (Required): ______________

Authorized Representative Name: ______________________________

Relationship to Patient ______________________ Date of Birth: ______________

CONSENT TO MARKETING AND TEXT MESSAGES

By checking and signing below, I agree to receiving:

☐ Marketing information from GBT, GBT Source, and GBT Partners on offers, educational materials, and market research related to my medical condition, treatment and/or my prescription medication. I also agree to participate in any future customer relationship marketing programs, such as a survey, if requested.

☐ Text messages by or on behalf of GBT Source at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing any goods or receiving support from GBT Source. Message and data rates may apply.

Patient Name (Required) ______________________________

Patient/Authorized Representative

Signature (Required): ______________________ Date (Required): ______________