ENROLLMENT FORM | To be completed by PRESCRIBER

Oxbryta® (voxelotor) tablets

GBT source™ SOLUTIONS

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

To prevent delays, complete **ALL** fields and fax form to (888) 418-4178. For additional assistance, call the phone number above.

GBT Source Solutions offers the following services: Benefit Investigation, Prior Authorization Assistance, Appeal Assistance, Financial Assistance for Eligible Patients, and Nurse Support. For more details on the services available to your patient, please download the GBT Source Patient Brochure at https://oxbryta.com/patient-resources.

STEP 1: Patient Information

Patient First Name	Middle Initial	Last Name
Address		Apt #
City	State	ZIP
DOB (mm/dd/yyyy)	Gender ☐ Male ☐ Female	
Patient Home Phone #	Patient Cell Phone #	
Patient Alternative Phone #	Patient Email Address	

Permission to leave message for patient? ☐ Yes ☐ No

Authorized Caregiver (Do Not Omit; Please Complete)

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

Permission to leave message with authorized caregiver on behalf of patient? ☐ Yes ☐ No

STEP 2: Insurance Information

Has the patient started therapy? ☐ Yes ☐ No

Is the patient insured? ☐ Yes ☐ No

Will the patient's prescription be 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

Complete the information below. If available, also fax a copy of front and back of patient's medical and prescription benefit insurance cards.

Medical/Health Insurance

Insurance Name	Phone #	Policy ID #	Group #
Policyholder 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

Office/Clinic/Institution 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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STEP 4: Diagnosis and Clinical Information

Patient Name	Patient DOB

Primary ICD-10 Diagnosis: ☐ **D57**
☐ Other: _____

List Concurrent Therapies/Medications	☐ I attest I am aware of drug-drug interaction potential
Drug and Nondrug Allergies	☐ No known drug allergies

STEP 5: Prescription Information for Oxbryta 500 mg/tab

Dose: **Oxbryta 500 mg tablets** | Quantity: ☐ **#90** ☐ Other: _____ | NDC # **72786-0101-01**

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

Number of Refills Authorized: _____
☐ No Refills

☐ I will submit e-prescription directly to specialty pharmacy

Please provide a compliant prescription if this section does not comply with your state's prescription laws. New York State Prescribers, please submit an e-script or Official New York Serialized Prescription with this enrollment form.

STEP 6: Physician Certification and Signature

FOR PRESCRIBER

Print Prescriber Name	Date

SIGN HERE

Prescriber Signature	Prescriber Signature
_____ (Dispense as Written/Do Not Substitute)	_____ (Substitution Permitted)

(PRESCRIBER MUST MANUALLY SIGN. Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.)

By signing above I, as the prescribing physician, certify that:

1) The information provided on this form was completed by me or at my direction. The above treatment is medically necessary for this patient and I will be supervising the patient's treatment, and the information provided herein is complete and accurate to the best of my knowledge.
2) I have informed my patient of the resources available in the GBT Source program and have confirmed my patient's (or their respective caregiver's) wishes to enroll in the program. I have obtained all required patient permissions and have complied with all federal and state laws to release the provided information to Global Blood Therapeutics, GBT Source Solutions, and its contractors and agents ("GBT") for the purposes described herein.
3) I understand that the information provided herein will be used for the purposes of GBT Source Solutions to investigate and verify the patient's insurance coverage benefits for Oxbryta, coordinate the dispensing and delivery of Oxbryta, assist in initiating or continuing therapy, provide prior authorization and appeals information, verify eligibility for a copay program and copay assistance foundation referrals, provide me and my patient with other education and support associated with Oxbryta, and for GBT internal business purposes such as conducting quality control, data analysis, and gathering feedback to improve patient support and resources.
4) I will not seek reimbursement for Oxbryta dispensed to the patient through the GBT Source Patient Assistance Program (PAP) from any government program or third-party insurer.
5) I have not received and will not receive any payment or benefit from GBT for prescribing Oxbryta.
6) I authorize the above prescription to be forwarded to the appropriate pharmacy utilizing the patient's benefit plan, and I understand that I must comply with my practicing state's specific prescription requirements. Any noncompliance with state-specific requirements may result in outreach to me by the pharmacy.

Read entire form, complete ALL form fields, then fax all pages to (888) 418-4178.

PATIENT AUTHORIZATION AND CONSENT
Oxbryta® (voxelotor) tablets

GBT source™ SOLUTIONS

TO BE COMPLETED BY **PATIENT** | **Fax to: (888) 418-4178** Phone: (833)-GBT-4YOU (833-428-4968)

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By signing this Patient Authorization form, I authorize my healthcare providers, pharmacies, and my health plan(s) to disclose and share my personal and medical Information (as defined below) with Global Blood Therapeutics, the manufacturer of Oxbryta, GBT Source Solutions, and its contractors and agents (all referred to as "GBT"). GBT may, in turn, disclose, use, and share my personal Information with my healthcare providers, pharmacies, and health plan(s). **INFORMATION TO BE SHARED** shall include personal and medical Information about me such as, but not limited to, my full name, address, telephone number, email address, birth date, health insurance benefits and coverage, financial information, and information about my medical condition(s) and treatment history. **MY INFORMATION MAY BE SHARED FOR THE FOLLOWING PURPOSES**: 1) Evaluate my insurance coverage benefits for Oxbryta, including prior authorization and appeals support; 2) Coordinate pharmacy dispensing and delivery of my medication; 3) Enrollment into or referral to financial assistance programs to help me pay for Oxbryta through my insurer, the Oxbryta copay assistance program, or other patient assistance programs; 4) Provide educational resources related to my medical condition and Oxbryta treatment, and support for initiating or continuing on therapy; 5) For internal use by GBT, including to conduct quality control, data analysis, and gather feedback to improve patient support and resources.

Information that is used or disclosed pursuant to an authorization may be subject to redisclosure by the receiver and no longer protected by the Health Insurance Portability and Accountability Act ("HIPAA"). **Signing this Authorization is optional. I understand that I do not have to sign this Authorization.** If I do not, my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits, will not be directly affected. However, if I do not sign, I will not be eligible to enroll into or receive services from GBT/GBT Source Solutions. **I understand that I am entitled to a signed copy of this Authorization**, which is valid for five (5) years from the date that I sign or the date I last enrolled, whichever comes first, unless a shorter period is required by law. **I have the right to cancel this Authorization at any time** by sending GBT a written notice, by fax to (888) 418-4178 or by mail to GBT Source, 680 Century Point, Lake Mary, Florida, 32746. If I cancel, this means that my Information will no longer be shared. However, this will not apply to my Information that may have already been used or shared as a result of this Authorization, or when it is required by law. If I cancel, I understand that I will no longer be able to receive the services listed above or assistance provided by GBT Source Solutions.

By checking these boxes and signing below:

☐ I agree to receive text messages by or on behalf of GBT Source Solutions at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing any goods or my enrollment in GBT Source Solutions. Message and data rates may apply. All carriers may not be supported.

☐ I agree to receive marketing information, educational and treatment support materials, and/or surveys related to my medical condition, Oxbryta, or GBT Source Solutions from GBT/GBT Source Solutions. I understand that my consent is not required as a condition of purchasing any goods or my enrollment in GBT Source Solutions.

PATIENT OR AUTHORIZED CAREGIVER

Print Patient Name		Patient Date of Birth
Print Name of Authorized Caregiver (if applicable)	Relationship to Patient	
Written Signature (Patient OR Authorized Caregiver)		Today's Date

SIGN HERE

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GBT SOURCE PATIENT ASSISTANCE PROGRAM (PAP)
Oxbryta® (voxelotor) tablets

GBT source™ SOLUTIONS

OPTIONAL | TO BE COMPLETED BY PATIENT

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For eligible patients prescribed Oxbryta who are uninsured or functionally uninsured

Please complete and sign to determine eligibility:

Are you a resident of the US or a US Territory? ☐ Yes ☐ No | Are you currently insured? ☐ Yes ☐ No

Are you enrolled in a Medicaid, Medicare, VA, Dept. of Defense, TRICARE, or any other state or federally funded health insurance plan? ☐ Yes ☐ No (Include copy of insurance and prescription cards.)

Have you been denied insurance coverage for Oxbryta?
☐ Yes ☐ No ☐ Not Known (Include copy of appeal and denial letters, if available.)

Current Annual Household Income $_____Number of persons in household _____
(Include before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income.)

PATIENT OR AUTHORIZED CAREGIVER

Print Patient Name	
Print Name of Authorized Caregiver (if applicable)	Relationship to Patient
Written Signature (Patient OR Authorized Caregiver)	Today's Date

SIGN HERE

By signing above, I certify that:

1) All the information provided above is true and correct, including my household income. I understand that assistance will end if the medication is no longer prescribed to me or if GBT Source becomes aware of fraud. I understand that completing this application does not guarantee that I qualify for patient assistance.

2) I understand that eligible patients may receive Oxbryta through the GBT Source Patient Assistance Program ("PAP") for up to twelve (12) months unless their insurance or financial circumstances change. If there is a change in my insurance or financial situation, I will inform GBT Source immediately. I understand that receiving Oxbryta for free is not tied to any requirement to use or purchase goods.

3) If I receive Oxbryta for free through the PAP, I will not seek reimbursement or credit for Oxbryta, nor sell or transfer Oxbryta to anyone else once provided. While taking Oxbryta, I will follow the direction of my treating physician.

4) I authorize the PAP and its administrator to forward this prescription to a dispensing pharmacy on my behalf.

5) I authorize GBT Source and/or its program administrator, under the Fair Credit Reporting Act, to obtain my credit report to verify the information provided and to determine if I am eligible for the PAP. This consent will be used to verify my income ONLY and will have NO effect on my credit score. I understand that proofs of income for all adults in my household may be required, such as copies of recent tax returns, unemployment checks, paycheck stubs, or bank statements.

6) I understand that GBT Source has the right to change the PAP requirements, change or end the PAP, or stop my assistance at any time with written notice.

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