PLEASE DO NOT SEND THIS FORM TO GSK

Vista Patient Support Program

Enrollment Form **Phone: 1-844-847-4392** (Mon – Fri, 8 am – 8 pm EST) **Fax: 1-844-410-0653**

ELIGIBILITY CRITERIA

(Enter information below)

☐ **I hereby confirm the patient:**

- Has severe eosinophilic asthma and is ≥18 years of age
- Is inadequately controlled with high-dose inhaled corticosteroids and an additional asthma controller(s) (e.g., long-acting beta$_2$-adrenergic agonist [LABA])
- Has a blood eosinophil (EOS) count ≥150 cells/μL (0.15 GI/L) at initiation of treatment **OR** ≥300 cells/μL (0.30 GI/L) in the previous 12 months (Actual blood EOS count: _____ GI/L Month of assessment: _____)
- Has experienced ≥2 exacerbations in the previous 12 months (Number of exacerbations: _____) **AND/OR** is on regular maintenance treatment with oral corticosteroids

PATIENT INFORMATION

(Place sticker or enter information below)

Name: _____

Date of Birth: MM / DD / YY Gender: ☐ M ☐ F

Address: _____

_____

Phone: _____

Email: _____

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening

PHYSICIAN INFORMATION

(Place stamp or enter information below) Please do not send this form to GSK.

Name: _____

Phone: _____

Fax: _____

Address: _____

_____

Email: _____

Would you like to receive post-injection reports?

☐ **Yes** ☐ **No**

MEDICATION INFORMATION

"I hereby certify that I have reviewed the NUCALA™ Product Monograph, and I am prescribing this medication for this patient in accordance with the intended use as outlined therein. I acknowledge that the patient's participation in the Vista Patient Support Program will be terminated in the event of use that is inconsistent with the Product Monograph."

Physician Signature: _____

License Number: _____

Date: MM / DD / YY

☐ Rx attached

OR

☐ ^{Pr}NUCALA™ (mepolizumab) 100 mg once every 4 weeks

Repeat: _____

PATIENT CONSENT

☐ I have read, understood, and agreed to the Patient Consent statement on reverse.

Patient Signature: _____ Email: _____ Date: MM / DD / YY

NUCALA™ (mepolizumab) is indicated as add-on maintenance treatment of adult patients with severe eosinophilic asthma who are inadequately controlled with high-dose inhaled corticosteroids and an additional asthma controller(s) (e.g., LABA), and have a blood eosinophil count of ≥150 cells/μL (0.15 GI/L) at initiation of treatment with NUCALA™ OR ≥300 cells/μL (0.3 GI/L) in the past 12 months. NUCALA™ is not indicated for other eosinophilic conditions or for relief of acute bronchospasm or status asthmaticus.

For more information:

Please consult the Product Monograph at gsk.ca/nucala/en for important information relating to contraindications, warnings and precautions, adverse reactions, drug interactions, dosing information and conditions of clinical use. The Product Monograph is also available by calling 1-800-387-7374. To report an adverse event, please call 1-800-387-7374.