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

☐ **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. LABA)
- Has a blood eosinophil 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
- Has experienced ≥2 exacerbations in the previous 12 months **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: _____

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening

PHYSICIAN INFORMATION

(Place stamp or enter information below)

Name: _____

Phone: _____ Fax: _____

Address: _____

Primary Enrollment/Office Contact: _____

Profession: _____

Phone: _____ Fax: _____
(If different from above) *(If different from above)*

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

☐ PrNUCALA™ (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.