# Nucala Co-pay Program Check Request Form

Please complete form and submit to be reimbursed

**Patients enrolled in Medicare and other government funded programs are not eligible.**

---

To ensure we are able to process your reimbursement, please be sure to:

1. Complete this form and document your expense; and
2. Provide proof of payment (e.g., receipt from healthcare provider and/or specialty pharmacy)

To submit form and proof of payment, you may mail or fax to the NUCALA Co-pay Program:

- GSK Co-pay Program
  PO BOX 1326
  Morristown, NJ 07962
- 866-728-8222 (fax)

Requests must meet all program criteria in order to be considered for reimbursement.
**The NUCALA Co-pay Program does not provide reimbursement for administration fees in Massachusetts, Minnesota and Rhode Island.**

---

**Please fill in information below for appropriate payments you have made to your healthcare provider and/or specialty pharmacy for your NUCALA cost-share:**

Patient Information:

Patient First Name (Print) | Patient Last Name (Print) | Date of birth

Street Address

City | State | Zip Code

Payment Date 1: Date of Service (mm dd yy) | $ __,___.__ Out-of-pocket costs | Co-pay Member ID

Payment Date 2: Date of Service (mm dd yy) | $ __,___.__ Out-of-pocket costs

---

Certification and Authorization:

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible out-of-pocket costs for the NUCALA medication I have already received. I have not and will not seek reimbursement of this expense from any other plan or party.

Patient Signature: ________________________________________ Date: ________________

©2021 GSK group of companies or its licensor. Printed in USA. NGADR494 October 2021