



GSK HCP PORTAL USER GUIDE

Exdensur

January 2026

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Header/Footer Links

HEADER LINKS

Name	URL
Nucala Logo	https://hcp.exdensurcopayprogram.com/Account

Name	URL
Privacy Policy	https://www.iqvia.com/about-us/privacy
Terms of Use	https://www.iqvia.com/about-us/terms-of-use
Contact Us	https://hcp.exdensurcopayprogram.com/Home/ContactUs
GSK Copay Terms and Conditions	https://www.gskforyou.com/programs/copay-assistance/
GSK Privacy Statement	https://privacy.gsk.com/en-us/privacy-notice/
GSK Terms of Use	https://us.gsk.com/en-us/legal-notices/

Login Page

The screenshot shows the login page for the Exdensur HCP Copay Portal. At the top left, there are logos for 'together with' and 'EXDENSUR (depemokimab)'. The main heading is 'Welcome to the Exdensur HCP Copay Portal'. Below this, a section titled 'To submit a medical copay claim you will need:' lists requirements for documentation, including Explanation of Benefits (EOB) or Claims Remittance Advice (EOP), and specific details like patient cost share, administration fees, patient names, and GSK product names. A note states that if submitting via mail or fax, HCP/Account information and provider address are also required. On the right side, there is a 'Sign in' section with input fields for 'Email' and 'Password', a 'Forgot password?' link, a 'Remember my email' checkbox, and a 'Sign In' button with a link to 'register your practice'. The footer contains a navigation menu with links for Privacy Policy, Terms of Use, Contact Us, GSK Copay Terms and Conditions, GSK Privacy Statement, and GSK Terms of Use, along with a copyright notice for 2023 GSK and a small GSK logo.

together
with

EXDENSUR
(depemokimab)

Welcome to the Exdensur HCP Copay Portal

To submit a medical copay claim you will need:

- Explanation of Benefits (EOB) or Claims Remittance Advice (EOP)
- Documentation provided via portal must include:
 - Patient cost share for the GSK drug covered in the program
 - Patient cost share for administration fee related to injection or infusion of the GSK drug covered in the program
 - Named patient who is covered / eligible for the GSK copay program
 - GSK product name or the associated J-Codes

If submitting via mail or fax, HCP / Account seeking reimbursement and provider address must also be included. See the [Contact Us](#) page for details.

Sign in

Email

Password [Forgot password?](#)

Remember my email

[Sign In](#) or [register your practice](#)

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Login Page

Forgot Password? -> Reset Your Password

Reset Password Email Sent

The screenshot shows the 'Reset Your Password' form. At the top left are the 'together with' and 'EXDENSUR' logos. The title 'Reset Your Password' is centered. Below the title, there is a paragraph: 'Please enter the email address associated with your account. You will receive an email with a link to reset your password. You will only receive an email if your practice has been approved and your email address has been registered at the practice.' Below this is an 'Email Address' label and a text input field. To the right of the input field is a 'Send Email' button. Below the input field is a reCAPTCHA widget with the text 'I'm not a robot' and 'EXDENSUR is changing its terms of service. See details.' To the right of the reCAPTCHA is a 'Need help?' section with contact information: 'Call Customer Support Phone: (888) 216-3003 Fax: (866) 728-8222 8:00 AM - 8:00 PM ET Mon-Fri'. At the bottom left, there are links for 'Privacy Policy', 'Terms of Use', 'Contact Us', 'GSK Copy Terms and Conditions', 'GSK Privacy Statement', and 'GSK Terms of Use'. At the bottom right is the 'GSK' logo. The footer text reads '©2023 GSK group of companies. All rights reserved.'

The screenshot shows the 'Reset Your Password' form after a successful email reset. The layout is identical to the previous screenshot, but the 'Send Email' button is now disabled (greyed out). The 'Email Address' input field is empty. The 'Need help?' section and footer are the same as in the previous screenshot.

Login Page

Reset Password

Email link brings user to Reset Your Password page

Reset Your Exdensur HCP Copay Portal Password

 donotreply@copayprogram.gsk.com
To

 This sender donotreply@copayprogram.gsk.com is from outside your organization.

Hello Test,

You recently asked to reset your Exdensur HCP Copay Portal password by email. Please click the button below to reset your password. Your reset link will be valid for 1440 minutes.

[Reset Password](#)

If you are still unable to access your account, or if you did not request a password reset, please [contact support](#).

Thank you,
Exdensur HCP Copay Portal Customer Support

Please do not reply to this message, which was sent from an unmonitored email address.

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Reset Your Password

New Password

Confirm Password

[Save](#) [Cancel](#)

Your password should have:

- at least 8 characters
- at least 1 lowercase letter (a-z)
- at least 1 uppercase letter (A-Z)
- at least 1 number (0-9)
- at least 1 special character, such as ! @ # \$ % ^ & * =

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Login Page

Reset Password

Error Messages

The screenshot shows the 'Reset Your Password' form with two input fields: 'New Password' and 'Confirm Password'. Both fields are highlighted with a red border, indicating they are required. Below the 'New Password' field, the text 'The New Password field is required.' is displayed. Below the 'Confirm Password' field, the text 'The Confirm Password field is required.' is displayed. To the right of the input fields, a box lists the password requirements: 'Your password should have: at least 8 characters, at least 1 lowercase letter (a-z), at least 1 uppercase letter (A-Z), at least 1 number (0-9), and at least 1 special character, such as ! @ # \$ % ^ & * = +'. At the bottom of the form, there are 'Save' and 'Cancel' buttons. The footer contains links for Privacy Policy, Terms of Use, Contact Us, GSK Copy Terms and Conditions, GSK Privacy Statement, and GSK Terms of Use, along with a copyright notice for 2023 GSK group of companies.

The screenshot shows the 'Reset Your Password' form with two input fields: 'New Password' and 'Confirm Password'. Both fields are filled with asterisks, indicating that the password requirements have been met. To the right of the input fields, a box lists the password requirements: 'Your password should have: at least 8 characters, at least 1 lowercase letter (a-z), at least 1 uppercase letter (A-Z), at least 1 number (0-9), and at least 1 special character, such as ! @ # \$ % ^ & * = +'. At the bottom of the form, there are 'Save' and 'Cancel' buttons. The footer contains links for Privacy Policy, Terms of Use, Contact Us, GSK Copy Terms and Conditions, GSK Privacy Statement, and GSK Terms of Use, along with a copyright notice for 2023 GSK group of companies.

Login Page

Password Updated

together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Welcome, Test

Your password has been updated.

Submit a Claim

Need help?
Call Customer Support
Phone: (888) 216-3003
Fax: (866) 728-8222
8:00 AM - 8:00 PM ET Mon-Fri

Recent Claims [See all claims](#)

Status	Confirmation #	Member ID	Patient	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
You haven't submitted any claims yet.								

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Register Your Practice

The screenshot shows the 'Create Practice Account' introduction page. It features the 'together with EXDENSUR' logo at the top left. The main heading is 'Create Practice Account' with a sub-heading 'Introduction'. The text explains that a representative from the prescribing physician's practice must complete the registration process. It states that before using the Exdensur HCP Copay Portal, each user must activate their account individually. It notes that user activation does not have to be completed at the time of practice registration but must be completed before using the portal. A list of required information for successful registration is provided: 1. User information including email address, 2. Practice location information, and 3. Prescriber licensing information, which includes a. Prescriber National Provider Identifier (NPI) and b. State License Number (optional). A note mentions that users will be asked to agree to the Exdensur HCP Copay Portal Agreement. A green 'Begin' button is located at the bottom of the main content area. The footer contains links for Privacy Policy, Terms of Use, Contact Us, GSK Copay Terms and Conditions, GSK Privacy Statement, and GSK Terms of Use, along with a copyright notice for 2023 GSK group of companies.

The screenshot shows the 'Create Practice Account' form. It features the 'together with EXDENSUR' logo at the top left. The main heading is 'Create Practice Account' with a sub-heading 'About The Practice'. The text asks the user to enter information requested below for verification. The form includes several input fields: Practice Name, Practice NPI, Tax ID, Street Address, Address Line 2 (optional), City, State, ZIP, Phone, Email Address, and Fax. A 'Payment Method' section is also present, with a dropdown menu set to 'Electronic' and a note that the electronic payment account is funded. A green 'Next' button is located at the bottom of the form. The footer contains links for Privacy Policy, Terms of Use, Contact Us, GSK Copay Terms and Conditions, GSK Privacy Statement, and GSK Terms of Use, along with a copyright notice for 2023 GSK group of companies.

Register Your Practice

Error Messages

together with EXDENSUR (depemokimab)

Create Practice Account

About The Practice

Please enter the information requested below. We will use this information to verify your practice.

Practice Name

Name is required.

Practice NPI Tax ID
NPI is required. Tax ID is required.

Street Address

Street Address is required.

Address Line 2 (optional)

City

City is required.

State ZIP
State is required. ZIP is required.

Phone Email Address
Phone is required. Email Address is required.

Fax
Fax is required.

Payment Method
You can receive payment for your claims by any of the methods below. Electronic payments require additional setup on our payment provider's website.
Electronic Your electronic payment account is funded.

Next

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About You

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Create Practice Account

About You

Please enter this information about yourself. We will send an account activation email to the email address you specify below. We may use the phone number below to contact you if additional information is required to verify your practice.

Email Address Your activation email will be sent to this address.

First Name

Last Name

Phone Number Extension
(###) ###-####

Role in Practice

Next

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Register Your Practice

Error Messages

The screenshot shows a web form titled "Create Practice Account" with a sub-heading "About You". The form includes several input fields, each with a red border and a red error message below it:

- Email Address:** "Your activation email will be sent to this address." Error: "Email is required."
- First Name:** Error: "First Name is required."
- Last Name:** Error: "Last Name is required."
- Phone Number:** Format: "(###) ###-####". Error: "Phone is required."
- Extension:** (Empty field)
- Role in Practice:** (Dropdown menu). Error: "User Role is required."

A green "Next" button is located at the bottom of the form. The footer contains links for "Privacy Policy", "Terms of Use", "Contact Us", "GSK Copay Terms and Conditions", "GSK Privacy Statement", and "GSK Terms of Use", along with the copyright notice "©2023 GSK group of companies. All rights reserved." and the GSK logo.

Register Your Practice

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Create Practice Account

About You

Please enter this information about yourself. We will send an account activation email to the email address you specify below. We may use the phone number below to contact you if additional information is required to verify your practice.

Email Address Your activation email will be sent to this address.

First Name

Last Name

Phone Number **Extension**

Role in Practice

Office/Billing Administrator

Next

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Create Practice Account

Additional Users

You can add up to three additional users at this practice, or skip this step and add more users after your account is activated.

Name	Email Address	Role	Admin
Test Testing	P55_Business_Analyst@iqvia.com	Office/Billing Administrator	<input type="checkbox"/>

Add a User

Next

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement | GSK Terms of Use
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Register Your Practice

Add User

Create Practice Account Additional Users

You can add up to three additional users at this practice.

Name	Email Address	Role
Test Testing	PSS_Business_Analyst@iqvia.com	Admin

User Form Fields:

- Email Address: (An activation email will be sent to this address.)
- First Name:
- Last Name:
- Phone Number: (Format: (999) 999-9999)
- Extension:
- Role in Practice: (Administrator)

Edit User

Users

Add a User

Name	Email Address	Role
Test Testing	PSS_Business_Analyst@iqvia.com	Administrator

User Form Fields:

- Email Address: (PSS_Business_Analyst@iqvia.com)
- First Name: (Test)
- Last Name: (Testing)
- Phone Number: (Format: (908) 432-5337)
- Extension:
- Role in Practice: (Officer/Billing Administrator)

Register Your Practice

About the Prescriber

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Create Practice Account

About the Prescriber

At least one prescriber from your practice must be added in order to verify the practice.

Prescriber First Name

Prescriber Last Name

NPI Number State License Number (optional)

[Next](#)

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Error Messages

together with EXDENSUR (depemokimab)

Create Practice Account

About the Prescriber

At least one prescriber from your practice must be added in order to verify the practice.

Prescriber First Name

First Name is required.

Prescriber Last Name

Last Name is required.

NPI Number State License Number (optional)
NPI Number is required.

[Next](#)

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Register Your Practice

Additional Prescribers

The screenshot shows the 'Additional Prescribers' step of the 'Create Practice Account' process. It features a table with columns for Name, NPI, and SLN. A single entry is shown with 'Tester Test' as the name and '1234567891' as the NPI. Below the table is an 'Add a Prescriber' link and a 'Next' button. The footer contains links for Privacy Policy, Terms of Use, Contact Us, GSK Copy Terms and Conditions, GSK Privacy Statement, and GSK Terms of Use, along with a copyright notice for 2023 GSK group of companies.

Name	NPI	SLN
Tester Test	1234567891	

Select Add a Prescriber

The screenshot shows the 'Select Add a Prescriber' step of the 'Create Practice Account' process. A modal form titled 'Prescriber' is open, containing input fields for First Name, Last Name, NPI Number, and State License Number (optional). The modal also includes 'Save' and 'Cancel' buttons. The background shows the 'Additional Prescribers' table from the previous step, with the 'Add a Prescriber' link highlighted.

Register Your Practice

Review Registration

Create Practice Account

Review Registration

Please review the information below before submitting your registration.

Practice [Edit](#)

IQtest

NPI: 1992259530

Tax ID: 12-3456789

Phone: (908) 432-5337

Fax: (908) 123-4567

Address:
123 ABC St.
Anywhere, IN 98765

Payments will be received by electronic transfer.
* Requires additional setup after registration.

[Next](#)

Users [Edit](#)

Name	Email Address	Role
Test Testing	PSS_Business_Analyst@iqvia.com	Office/Billing Administrator

Prescribers [Edit](#)

Name	NPI	SLN
Tester Test	1234567891	

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Practice Agreement

Create Practice Account

Practice Agreement

Please sign below the following Terms and Conditions to indicate your understanding and acceptance of the terms and conditions of participation of this GSK Copay Program.

I certify that the information provided in claims submitted to IQVIA Inc., Patient Access and Affordability Solutions Division as part of this GSK Copay Program will be accurate; that expenses requested for payments will be eligible patient co-pay, co-insurance, or deductible expenses, actually incurred and not paid by the patient's insurance, Flexible Spending Account, Health Savings Account, or any other payer; and that I would, in the ordinary course of my practice, have charged my patient for such out-of-pocket expenses. I also certify that I will ensure that each patient for whom submits documentation under this Program (i) will not be purchasing their prescriptions with benefits from Medicare, including Medicare Part D or Medicare Advantage Plans; Medicaid, including Medicaid Managed Care or Alternative Benefit Plans ("ABPs") under the Affordable Care Act; Medicaid; Veterans Administration ("VA"); Department of Defense ("DoD"); TRICARE; or any similar state-funded programs, such as medical or pharmaceutical assistance programs; and (ii) will meet the other eligibility criteria for the program. Any other expenses, including, but not limited to, out-of-network amounts not covered by patient's insurance, are not eligible for payment under this Program. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

I also understand that IQVIA reserves the right to verify submitted claims information at any time.

Acknowledged and Agreed

Enter your name to accept

first last

I'm not a robot CAPTCHA

[Finish](#)

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Register Your Practice

Error Messages

The screenshot shows the 'Create Practice Account' page with the 'Practice Agreement' section. A large text box contains a detailed agreement, and below it, a checkbox for 'Acknowledged and Agreed' is unchecked. A red error message states 'You must accept to continue.' Below this, there are two input fields for 'first' and 'last' names, both with red borders and error messages: 'Please enter your first name.' and 'Please enter your last name.' At the bottom, there is a 'Finish' button and a 'GSK' logo.

Registration Successful

The screenshot shows the 'Create Practice Account' page with the 'Registration Successful' message. A green checkmark icon is followed by the text 'Your registration was successfully submitted.' Below this, a thank-you message states: 'Thank you for registering your practice for the Exdensur HC? Copay Portal. We are currently processing your request. You and any users added during registration will receive an account notification email within two (2) business days.' A note below says: 'Please note, you will not be able to sign in until your practice has been approved and your account is activated.' A green 'Done' button is visible. On the right side, there is a 'Need help?' section with contact information: 'Call Customer Support Phone: (888) 216-3003 Fax: (866) 728-8222 8:00 AM - 8:00 PM ET Mon-Fri'. At the bottom, there is a 'GSK' logo and footer text.

Register Your Practice



Registration Submitted

Exdensur HCP Copay Portal Practice Registration Submitted

 donotreply@copayprogram.gsk.com
To

 This sender donotreply@copayprogram.gsk.com is from outside your organization.

Hello Test,

Thank you for registering your practice for the Exdensur HCP Copay Portal. We are currently processing your request. You and any users added during registration will receive an account notification email within two (2) business days.

Thank you,
Exdensur HCP Copay Portal Customer Support

Please do not reply to this message, which was sent from an unmonitored email address.

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HCP Copay Portal Account Approved

Activate Your Exdensur HCP Copay Portal Account

 donotreply@copayprogram.gsk.com
To

 This sender donotreply@copayprogram.gsk.com is from outside your organization.

Test,

Your practice has been approved. Please click the button below to activate your account.

https://uat.opushealth.com/GSKExdensurBuyAndBill/Home/ActivateAccount?username=PSS_Business_Analyst%40iqvia.com&code=2371648133419869168164732153024427228171022422317967137186119762

Thank you,
Exdensur HCP Copay Portal Customer Support

Please do not reply to this message, which was sent from an unmonitored email address.

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Account Activation

Activate Account

Account Activation: Set Password

together with EXDENSUR (depemokimab)

Account Activation

Please set your password.

Password

Confirm Password

Your password should have:

- at least 8 characters
- at least 1 lowercase letter (a-z)
- at least 1 uppercase letter (A-Z)
- at least 1 number (0-9)
- at least 1 special character, such as ! @ # \$ % ^ & * + =

[Save](#) [Cancel](#)

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Error Messages

together with EXDENSUR (depemokimab)

Account Activation

Please set your password.

Password

The Password field is required.

Confirm Password

The Confirm Password field is required.

Your password should have:

- at least 8 characters
- at least 1 lowercase letter (a-z)
- at least 1 uppercase letter (A-Z)
- at least 1 number (0-9)
- at least 1 special character, such as ! @ # \$ % ^ & * + =

[Save](#) [Cancel](#)

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Account Activated

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Account Activated

✓ Your account has been activated.

[Click here to sign in to the Exdensur HCP Copy Portal.](#)

[Save](#) [Cancel](#)

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Navigation Menu (Home)

together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Welcome, Test

[Submit a Claim](#)

Need help?
Call Customer Support
Phone: (888) 216-3003
Fax: (866) 728-8222
8:00 AM – 8:00 PM ET Mon-Fri

Recent Claims [See all claims](#)

Status	Confirmation #	Member ID	Patient	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
You haven't submitted any claims yet.								

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Navigation Menu (Contact Us)

together with **EXDENSUR**
(depemokimab)

Contact Us

Customer Support
Phone: (888) 216-3003
Fax: (866) 728-8222
8:00 AM – 8:00 PM ET Mon-Fri

Need to submit by mail or fax? Download the [claim form](#) to help make sure you include all the necessary information.

Submit by Mail:
Attn: Claims Processing Dept.
IQVIA, Inc.
430 Mountain Ave Suite 105
New Providence, NJ 07974

Submit by Fax:
(866) 728-8222

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Navigation Menu (Practice -> Account)

Practice -> Account

The screenshot shows the 'Practice' account page. At the top, there are navigation links: Home, Claims, Practice, and Contact Us. The user is identified as PSS_Business_Analyst@iqvia.com. The main content area is titled 'Practice' and features a profile for 'IQtest' with NPI: 1992259530 and Tax ID: 12-3456789. There are three management links: Manage Patients, Manage Users, and Manage Prescribers. The 'Address' section shows 123 ABC St, Anywhere, IN 98765. The 'Communications' section lists Phone: (908) 432-5337, Fax: (908) 123-4567, and Email: PSS_Business_Analyst@iqvia.com. The 'Payment Method' section states that payments are being electronically transferred and provides a link to 'Manage Electronic Payments'. An 'Edit' button is located at the bottom of the main content area. The footer contains legal notices and a copyright notice for 2023 GSK group of companies.

Edit Practice

The screenshot shows the 'Edit Practice' form. It includes the same navigation and user information as the previous page. The form fields are: Practice Name (IQtest), Practice NPI (1992259530), Tax ID (12-3456789), Street Address (123 ABC St), Address Line 2 (optional), City (Anywhere), State (Indiana), ZIP (98765), Phone ((908) 432-5337), Email Address (PSS_Business_Analyst@iqvia.com), and Fax ((908) 123-4567). The 'Payment Method' section is expanded, showing a dropdown menu set to 'Electronic' with a note: 'Your electronic payment account is funded.' There are 'Save' and 'Cancel' buttons at the bottom of the form. The footer is identical to the previous page.

Navigation Menu (Practice -> Account)



Manage Electronic Payments

Navigation Menu (Practice -> Users)

Practice -> Users

Select Manage Users from Account Page or Users from dropdown menu

The screenshot shows the 'Users' management interface. At the top, there are navigation links for Home, Claims, Practice, and Contact Us. The main heading is 'Users'. Below it, there is an 'Add a User' link. A table lists the current users:

Name	Email Address	Role	Administrator
Test Testing	PSS_Business_Analyst@iqvia.com	Office/Billing Administrator	<input type="checkbox"/> Edit

At the bottom of the page, there is a footer with links for Privacy Policy, Terms of Use, Contact Us, GSK Copy Terms and Conditions, GSK Privacy Statement, and GSK Terms of Use. The copyright notice reads: ©2023 GSK group of companies. All rights reserved.

Add a User

The screenshot shows the 'Add a User' modal form. The form fields are:

- Email Address: [Text Input]
- First Name: [Text Input]
- Last Name: [Text Input]
- Phone Number: [Text Input]
- Extension: [Text Input]
- Role in Practice: Administrator (selected)

Below the form, there is a description of the Administrator role: 'Administrators can manage users and prescribers at the practice.' There are 'Save' and 'Cancel' buttons at the bottom of the modal.

Edit User

The screenshot shows the 'Edit User' modal form. The form fields are pre-filled with the user's details:

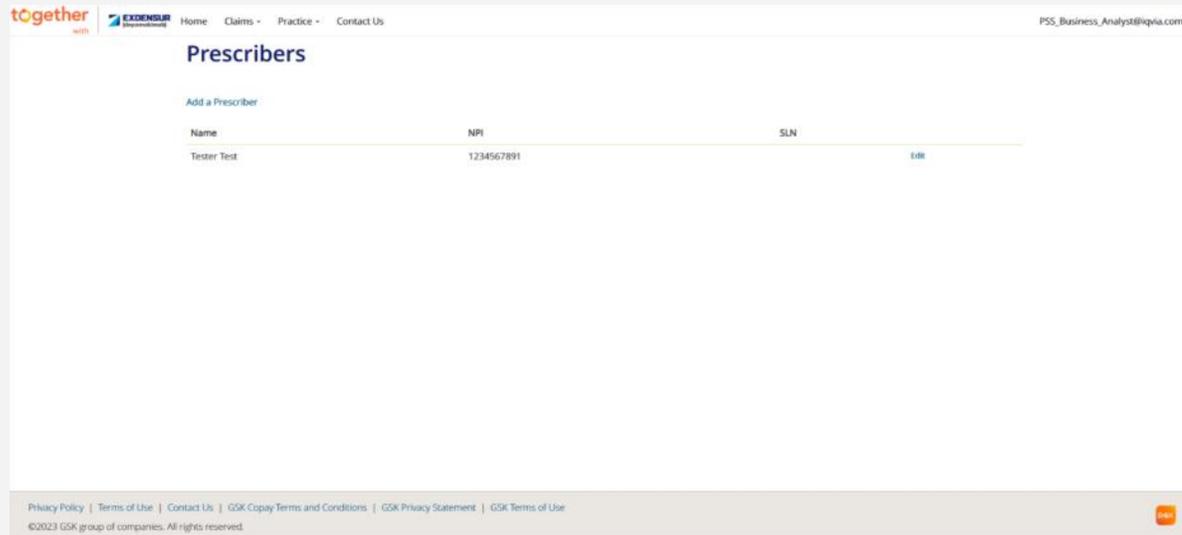
- Email Address: PSS_Business_Analyst@iqvia.com
- First Name: Test
- Last Name: Testing
- Phone Number: 0981-432-5137
- Extension: [Empty]
- Role in Practice: Administrator (selected)

Below the form, there is a description of the Administrator role: 'Administrators can manage users and prescribers at the practice.' There are 'Save' and 'Cancel' buttons at the bottom of the modal.

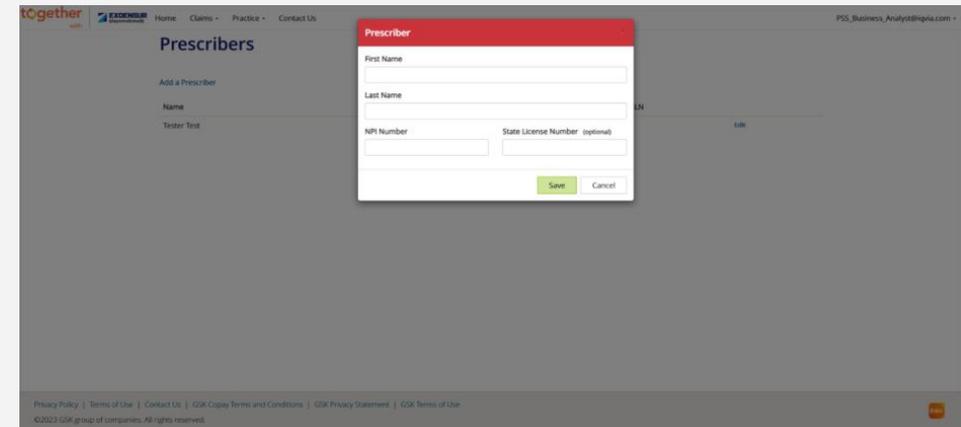
Navigation Menu (Practice -> Prescribers)

Practice -> Prescribers

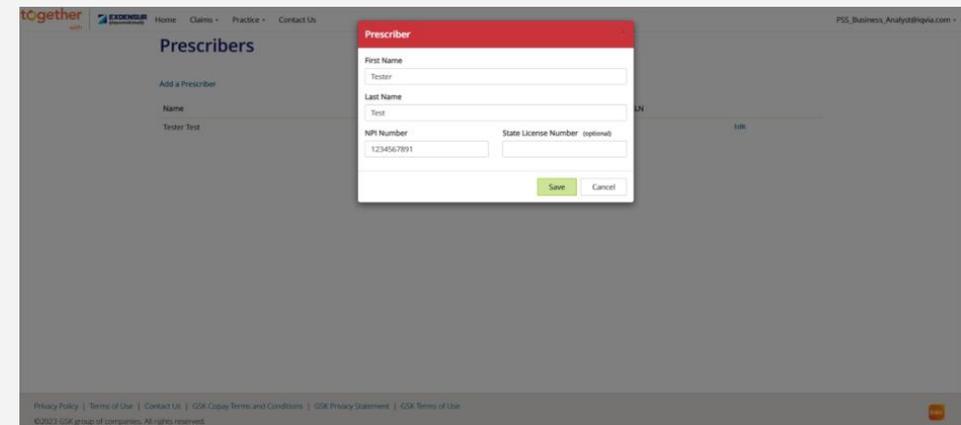
Select Prescribers Users from Account Page or Prescribers from dropdown menu



Add a Prescriber



Edit Prescriber



Navigation Menu (Practice -> Patients)

Practice -> Patients

Select Manage Patients from Account Page Patients from Prescriber drop down menu

together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Patients

Find a patient already associated to your practice

First Name Last Name

Additional registration options

Add a Registered Patient
Search for a registered patient and add them to your practice.

Register a New Patient
Register a new patient who is not already in the program.

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Navigation Menu (Practice -> Patients)

Patient Search

together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Patients

Find a patient already associated to your practice:

First Name Last Name

Additional registration options:

Add a Registered Patient
Search for a registered patient and add them to your practice.

Register a New Patient
Register a new patient who is not already in the program.

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together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Patients

Find a patient already associated to your practice:

First Name Last Name

Additional registration options:

Add a Registered Patient
Search for a registered patient and add them to your practice.

Register a New Patient
Register a new patient who is not already in the program.

Name ^	Date Of Birth	ZIP	
TEST TESTING	01/01/1931	99999	View Submit Claim

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Navigation Menu (Practice -> Patients)

Patient Record: View

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Patient

Balance will be visible after next claim.
PLEASE NOTE: The starting and remaining balances are subject to change according to the program terms and conditions.

[Click here to access your patient's virtual copy card](#)

[Submit a Claim](#)

Name TESTER TESTCARD	Group OH8914071	Member ID Z99100100483
Date of Birth 01/01/1983	Gender Male	
Address 123 MAIN STREET ANYWHERE, IN 12345	Insurance Type <input checked="" type="radio"/> Prescription <input type="radio"/> Medical	
Home Phone (908) 432-5337		
Email MICHAEL.FERGUSON2@IQVIA.COM		

[Edit](#) [Close](#)

Status	Confirmation #	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount	
New Claim	147812	Test, Tester		12/3/2025			View

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Patient Record: Edit

together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Patient

First Name TESTER	Last Name TESTCARD	Group OH8914071
Date of Birth 01/01/1983	Gender Male	Member ID Z99100100483
Street Address 123 MAIN STREET	Address Line 2 (optional) 2ND FLOOR	<small>If your patient does not have prescription insurance, please call Together with EXDENSUR at 1-844-Call-TWGSK (1-844-225-5894) 8 AM to 8 PM Eastern Time, Monday through Friday.</small>
City ANYWHERE	State Indiana	ZIP 12345
Phone (908) 432-5337	<input checked="" type="radio"/> Home <input type="radio"/> Mobile	
Email MICHAEL.FERGUSON2@IQVIA.COM	Insurance Name Aetna	
	Insurance BIN 610502	
	Insurance Group AP21	
	Insurance PCN SE	

Select an Insurance Type
 Prescription Medical

Electronic Signature
 Consent received.

[Save](#) [Cancel](#)

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Navigation Menu (Practice -> Patients)

Patient Record: Enrolled without patient consent received

Patient

No claims can be submitted until patient consent is in place.

Name: TEST TESTING
Group: OH8914051
Member ID: 297100100346

Date of Birth: 01/01/1931
Gender: Male

Address: 123 MAIN STREET, ANY, IN 99999
Insurance Type: Prescription (selected), Medical

Medical Insurance Name: Aetna
Medical Insurance ID #: W123456789

Mobile Phone: (908) 432-5337
Email: PSS_BUSINESS_ANALYST@IQVIA.COM

Electronic Signature: Awaiting online consent. [Resend email](#)

[Edit](#) [Close](#)

Status	Confirmation #	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
You haven't submitted any claims yet.						

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Patient Record: Enrolled with patient consent received

Patient

Patient information has been updated.

Balance will be visible after next claim. [Click here to access your patient's virtual copy card](#)

PLEASE NOTE: The starting and remaining balances are subject to change according to the program terms and conditions.

[Submit a Claim](#)

Name: TESTER TESTCARD
Group: OH8914071
Member ID: 299100100483

Date of Birth: 01/01/1983
Gender: Male

Address: 123 MAIN STREET, 2ND FLOOR, ANYWHERE, IN 12345
Insurance Type: Prescription (selected), Medical

Insurance Name: Aetna
Insurance BIN: 610502
Insurance Group: AP21
Insurance PCN: SE

Home Phone: (908) 432-5337
Email: MICHAEL.FERGUSON2@IQVIA.COM

Electronic Signature: Consent received.

[Edit](#) [Close](#)

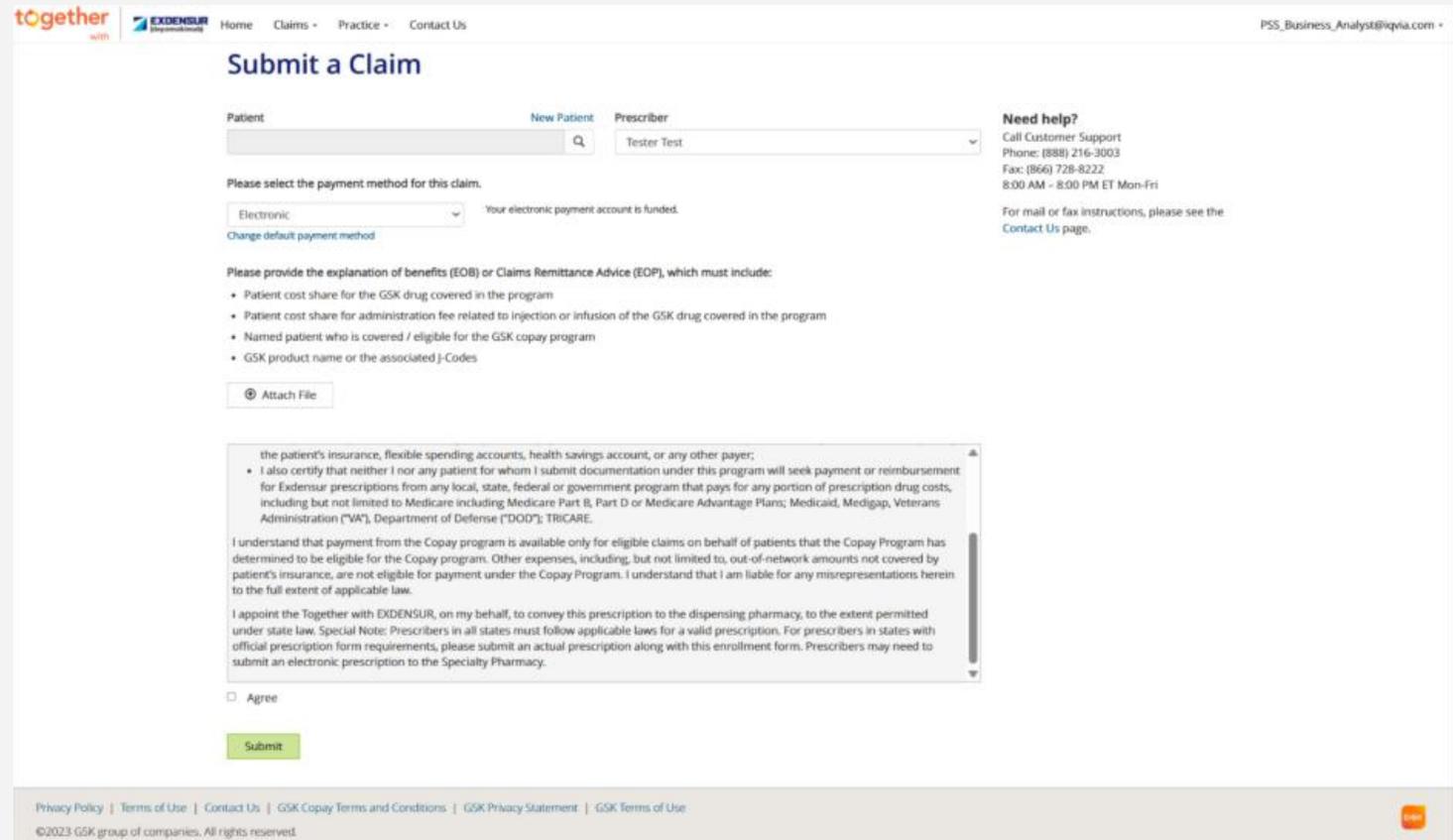
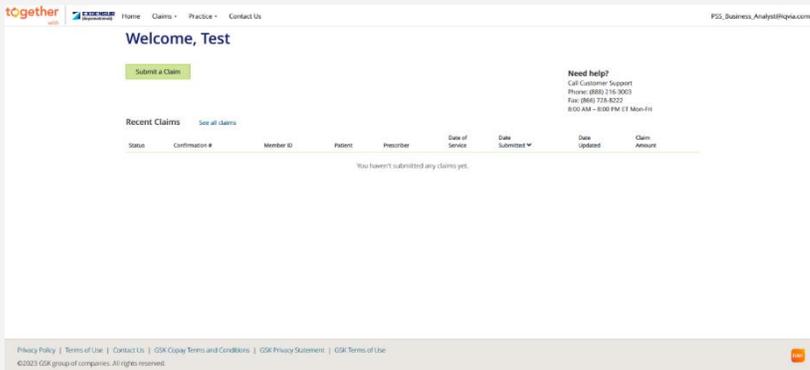
Status	Confirmation #	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
New Claim	147812	Test, Tester		12/3/2025		View

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Navigation Menu (Claims)

Claims -> Submit a Claim

Patient and prescriber are prepopulated if selected from patient screen or patient search results



Navigation Menu (Claims -> Submit a Claim)

Navigation Menu (Claims -> Submit a Claim)

The screenshot displays a web interface for submitting a claim. At the top left, there are logos for 'together with' and 'EXDENSUR (depemokimab)'. The navigation menu includes 'Home', 'Claims', 'Practice', and 'Contact Us'. The user's email address, 'PSS_Business_Analyst@iqvia.com', is visible in the top right corner. The main content area features a large heading 'Claim Submitted' and a green checkmark icon followed by the text 'The claim has been successfully submitted.' Below this, it states 'The confirmation number is 147812.' and 'You will be notified once the claim is approved.' A link 'Back to home page' is provided. The footer contains a list of links: 'Privacy Policy', 'Terms of Use', 'Contact Us', 'GSK Copay Terms and Conditions', 'GSK Privacy Statement', and 'GSK Terms of Use', along with the copyright notice '©2023 GSK group of companies. All rights reserved.' and a small orange icon.

Navigation Menu (Claims)

Add a Patient (Has a copay card)

The screenshot shows a web form titled "Patient" for adding a patient with a copay card. The form includes the following fields and options:

- First Name:** Test
- Last Name:** Testing
- Date of Birth:** 01/01/1931
- Gender:** Male
- Street Address:** 123 MAIN STREET
- Address Line 2 (optional):** (empty)
- City:** Any
- State:** Indiana
- ZIP:** 99999
- Phone:** (908) 432-5337
- Mobile:** (selected)
- Email:** PSS_Business_Analyst@iqvia.com
- Does the patient have a copay card?:** Yes (selected), No
- Group:** (empty dropdown)
- Member ID:** (empty text field)
- Medical Insurance Name:** Aetna
- Medical Insurance ID #:** W5478956231
- Select an Insurance Type:** Prescription, Medical (selected)

Buttons: Save, Cancel

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The screenshot shows the same "Add a Patient" form, but with the following differences:

- Group:** CH8914041
- Member ID:** 296100105382
- Medical Insurance ID #:** W5478956231

Buttons: Save, Cancel

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Navigation Menu (Claims)

Patient Added to Practice

The screenshot shows a web application interface for patient management. At the top, there is a navigation bar with the 'together with EXDENSUR' logo and a menu with 'Home', 'Claims', 'Practice', and 'Contact Us'. The user's email 'PSS_Business_Analyst@iqvia.com' is visible in the top right corner. The main heading is 'Patient'. A green notification bar states 'Patient has been added.' Below it, a yellow warning bar says 'No claims can be submitted until patient consent is in place.' The patient's details are displayed in two columns:

Name	TEST TESTING	Group	OH8914051	Member ID	297100100346
Date of Birth	01/01/1931	Gender	Male		
Address	123 MAIN STREET ANY, IN 99999	Insurance Type	<input type="radio"/> Prescription <input checked="" type="radio"/> Medical		
Mobile Phone	(908) 432-5337	Medical Insurance Name	Aetna		
Email	PSS_BUSINESS_ANALYST@IQVIA.COM	Medical Insurance ID #	W123456789		

Below the details, there is an 'Electronic Signature' section with a warning icon and the text 'Awaiting online consent', and a 'Resend email' link. At the bottom of the details are 'Edit' and 'Close' buttons. Below this is a table with the following headers: 'Status', 'Confirmation #', 'Prescriber', 'Date of Service', 'Date Submitted', 'Date Updated', and 'Claim Amount'. The table is currently empty, with a message below it stating 'You haven't submitted any claims yet.' The footer contains links for 'Privacy Policy', 'Terms of Use', 'Contact Us', 'GSK Copy Terms and Conditions', 'GSK Privacy Statement', and 'GSK Terms of Use', along with the copyright notice '©2023 GSK group of companies. All rights reserved.' and a small orange logo.

Navigation Menu (Claims)

Enroll a Patient (Does not have a copay card)

Patient

First Name: [Text] Last Name: [Text] Does the patient have a copay card? Yes No

Date of Birth: [Text] Gender: [Dropdown] Group: [Dropdown]

Street Address: [Text] Address Line 2 (optional): [Text] City: [Text] State: [Dropdown] ZIP: [Text]

Phone: [Text] Home: Mobile: Email: [Text] Welcome Contact Preference: [Dropdown]

Electronic Signature
The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)
[Dropdown]

Consent
I certify that the information provided above is true and that EXDENSUR is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for EXDENSUR would be collected from the patient upon treatment. I appoint the Together with EXDENSUR, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the EXDENSUR Copay Program.
Enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?
 Yes No

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medicaid, Veterans Affairs (VA), Department of Defense (DoD) programs or Tricare. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also eligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may use this program even if they seek to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?
 Yes No

Commercially insured?
 Yes No

Save **Cancel**

Phone: [Text] Home: Mobile:

(908) 432-5337

Email: [Text] Welcome Contact Preference: [Dropdown]

PSS_Business_Analyst@iqvia.com

SMS

Email

SMS

Please indicate your preferred method for receiving your eConsent and Smartcard Welcome communication, which will include copay details: If you select SMS, you will be asked to consent to receive text messages. Message and data rates may apply.

I confirm that the patient provided explicit consent to receive their eConsent message and relevant GSK communications via SMS to the mobile number they provided.

Electronic Signature
The patient will receive a communication via preferred method requesting electronic signature.

Error Messages

Patient

First Name: [Text] Last Name: [Text] Does the patient have a copay card? Yes No

Date of Birth: [Text] Gender: [Dropdown] Group: [Dropdown]

Street Address: [Text] Address Line 2 (optional): [Text] City: [Text] State: [Dropdown] ZIP: [Text]

Phone: [Text] Home: Mobile: Email: [Text] Welcome Contact Preference: [Dropdown]

Electronic Signature
The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)
[Dropdown]

Consent
I certify that the information provided above is true and that EXDENSUR is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for EXDENSUR would be collected from the patient upon treatment. I appoint the Together with EXDENSUR, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the EXDENSUR Copay Program.
Enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?
 Yes No **Please make a selection**

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medicaid, Veterans Affairs (VA), Department of Defense (DoD) programs or Tricare. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they seek to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?
 Yes No **Please make a selection**

Commercially insured?
 Yes No **Please make a selection**

Save **Cancel**

Navigation Menu (Claims)

NUCALA Gateway Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Patient

First Name Last Name

First Name is required. Last Name is required.

Date of Birth Gender

Date of Birth is required. Gender is required.

Street Address

Street Address is required.

Address Line 2 (optional)

City

City is required.

State ZIP

State is required. ZIP is required.

Phone Home Mobile

Phone is required.

Email

Email is required.

Does the patient have a card?
 Yes No

Co-pay Card GRP #

Co-pay Card ID #

Insurance Name

Insurance Name is required.

Insurance BIN

Insurance BIN is required.

Insurance Group

Insurance PCN

Insurance PCN is required.

Electronic Signature
The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)

Indication

Please make a selection.

I certify that the information provided above is true and that NUCALA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out-of-pocket cost for NUCALA would be collected from the patient upon treatment. I appoint the NUCALA Gateway, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please provide authorization to proceed.

Please answer the questions below to see if your patient may qualify for the NUCALA Co-pay Program.

Is your patient enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?

Yes No Your patient is not eligible for the NUCALA Co-Pay Program at this time. Please contact Gateway to NUCALA for more information at 1 844 4 NUCALA (1 844 468 2252).

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs or Tricare. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they elect to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Is your patient a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?

Yes No Your patient is not eligible for the NUCALA Co-Pay Program at this time. Please contact Gateway to NUCALA for more information at 1 844 4 NUCALA (1 844 468 2252).

Does the Patient have commercial insurance?

Yes No Your patient is not eligible for the NUCALA Co-Pay Program at this time. Please contact Gateway to NUCALA for more information at 1 844 4 NUCALA (1 844 468 2252).

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Patient

First Name Last Name

Cardinal#N Cardinal#N

Date of Birth Gender

01/01/2000 Female

Street Address

123 Main Street

Address Line 2 (optional)

City

Any

State ZIP

New Jersey 12345

Phone Home Mobile

(333) 333-3333

Email

Jessica.Rubin2@iqvia.com

Does the patient have a card?
 Yes No

Co-pay Card GRP #

CH8912101

Co-pay Card ID #

Insurance Name

Test Payer

Insurance BIN

123454

Insurance Group

6565

Insurance PCN

656

Electronic Signature
The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)

Indication

Severe Asthma

I agree to the NUCALA Copay Terms & Conditions

I certify that the information provided above is true and that NUCALA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out-of-pocket cost for NUCALA would be collected from the patient upon treatment. I appoint the NUCALA Gateway, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the NUCALA Co-pay Program.

Is your patient enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?

Yes No

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs or Tricare. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they elect to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Is your patient a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?

Yes No

Does the Patient have commercial insurance?

Yes No

This patient is already registered at your practice.

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Navigation Menu (Claims)



Prescription Insurance

together with EXDENSUR Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Patient

First Name: Last Name:
 Date of Birth: Gender:
 Street Address:
 Address Line 2 (optional):
 City:
 State: ZIP:
 Phone: Home Mobile
 Email:

Does the patient have a copy card?
 Yes No

Group:
 Member ID:

If your patient does not have prescription insurance, please call Together with EXDENSUR at 1-844-Call-TWGSK (1-844-225-5894) 8 AM to 8 PM Eastern Time, Monday through Friday.

Select an Insurance Type
 Prescription Medical

Insurance Name:
 Insurance BIN:
 Insurance Group:
 Insurance PCN:

Electronic Signature
 The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)

I certify that the information provided above is true and that EXDENSUR is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for EXDENSUR would be collected from the patient upon treatment. I appoint the Together with EXDENSUR, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the EXDENSUR Copay Program.
 Enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?
 Yes No

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD) programs or Tricare. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they seek to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?
 Yes No

Commercially insured?
 Yes No

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Medical Insurance

together with EXDENSUR Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Patient

First Name: Last Name:
 Date of Birth: Gender:
 Street Address:
 Address Line 2 (optional):
 City:
 State: ZIP:
 Phone: Home Mobile
 Email:

Does the patient have a copy card?
 Yes No

Group:
 Member ID:

If your patient does not have prescription insurance, please call Together with EXDENSUR at 1-844-Call-TWGSK (1-844-225-5894) 8 AM to 8 PM Eastern Time, Monday through Friday.

Select an Insurance Type
 Prescription Medical

Medical Insurance Name:
 Medical Insurance ID #:

Electronic Signature
 The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)

I certify that the information provided above is true and that EXDENSUR is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for EXDENSUR would be collected from the patient upon treatment. I appoint the Together with EXDENSUR, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the EXDENSUR Copay Program.
 Enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?
 Yes No

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD) programs or Tricare. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they seek to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?
 Yes No

Commercially insured?
 Yes No

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Navigation Menu (Claims)

Patient Not Eligible

together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Patient

First Name: Test Last Name: Testing

Date of Birth: 01/01/1931 Gender: Male

Street Address: 123 MAIN STREET

City: Any State: Indiana ZIP: 99999

Phone: (908) 432-5337 Email: PSS_Business_Analyst@iqvia.com

Does the patient have a copay card? Yes No

Group: QH8914051

Member ID: #####

Select an Insurance Type: Prescription Medical

Medical Insurance Name: Aetna

Medical Insurance ID #: W5478956231

Electronic Signature: The patient will receive an email requesting electronic signature.

Preferred Language (if other than English):

I certify that the information provided above is true and that EXDENSUR is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for EXDENSUR would be collected from the patient upon treatment. I appoint the Together with EXDENSUR, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the EXDENSUR Copay Program.

Enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?

Yes No **Your patient is not eligible for the EXDENSUR Copay Program at this time. Please contact Together with EXDENSUR for more information at 1-844-Call TWGSK (1-844-225-5894).**

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medicaid, Veterans Affairs (VA), Department of Defense (DOD) programs or TRICARE. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they seek to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity or HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?

Yes No **Your patient is not eligible for the EXDENSUR Copay Program at this time. Please contact Together with EXDENSUR for more information at 1-844-Call TWGSK (1-844-225-5894).**

Commercially Insured?

Yes No **Your patient is not eligible for the EXDENSUR Copay Program at this time. Please contact Together with EXDENSUR for more information at 1-844-Call TWGSK (1-844-225-5894).**

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Patient Added: Awaiting patient consent

together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Patient

Patient has been added.

No claims can be submitted until patient consent is in place.

Name: TEST TESTING Group: QH8914051 Member ID: Z97100100346

Date of Birth: 01/01/1931 Gender: Male

Address: 123 MAIN STREET ANY, IN 99999

Mobile Phone: (908) 432-5337

Email: PSS_BUSINESS_ANALYST@IQVIA.COM

Insurance Type: Prescription Medical

Medical Insurance Name: Aetna

Medical Insurance ID #: W123456789

Electronic Signature:

Status	Confirmation #	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
You haven't submitted any claims yet.						

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Navigation Menu (Claims)



Patient Consent

Next step: need your electronic signature

 donotreply@copayprogram.gsk.com
To

Electronic Signature Needed — Patient HIPAA Authorization

Greetings from the Exdensur Copay Program. Your provider recently submitted an enrollment request on your behalf for the Exdensur Copay Program.

eConsent is required to activate your copay card and participate in the copay program.

Please complete this request by: 12/08/2025. After 12/08/2025, the link to your eConsent will expire and no longer be valid.

Please click the button below to complete your enrollment.

[Click here to sign Patient HIPAA Authorization](#)

Your access code to the eConsent is your birthdate, in the following format: MM/DD/YYYY

If you have any questions about this email, please call the Exdensur Copay Program at 1-844-Call-TWGSK (1-844-225-5894).

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Navigation Menu (Claims)

Claims -> Claims History

together with EXDENSUR (depemokimab) Home Claims Practice Contact Us PSS_Business_Analyst@iqvia.com

Claim History

Submit a Claim Download claim history

Filter claims...

Status	Confirmation #	Member ID	Patient	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
New Claim	147812	299100100483	TESTCARD, TESTER	Test, Tester		12/3/2025		View
New Claim	147808	297100100411	TEST, MIKE	Test, Tester		12/3/2025		View
New Claim	147801	297100100411	TEST, MIKE	Test, Tester		12/2/2025		View
New Claim	147800	297100100411	TEST, MIKE	Test, Tester		12/2/2025		View
New Claim	147799	297100100411	TEST, MIKE	Test, Tester		12/2/2025		View
New Claim	147798	297100100411	TEST, MIKE	Test, Tester		12/2/2025		View

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Download Claim History

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Claim History

Submit a Claim Download claim history

Filter claims...

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New Claim	147812	299100100483	TESTCARD, TESTER	Test, Tester		12/3/2025		View
New Claim	147808	297100100411	TEST, MIKE	Test, Tester		12/3/2025		View
New Claim	147801	297100100411	TEST, MIKE	Test, Tester		12/2/2025		View
New Claim	147800	297100100411	TEST, MIKE	Test, Tester		12/2/2025		View
New Claim	147799	297100100411	TEST, MIKE	Test, Tester		12/2/2025		View
New Claim	147798	297100100411	TEST, MIKE	Test, Tester		12/2/2025		View

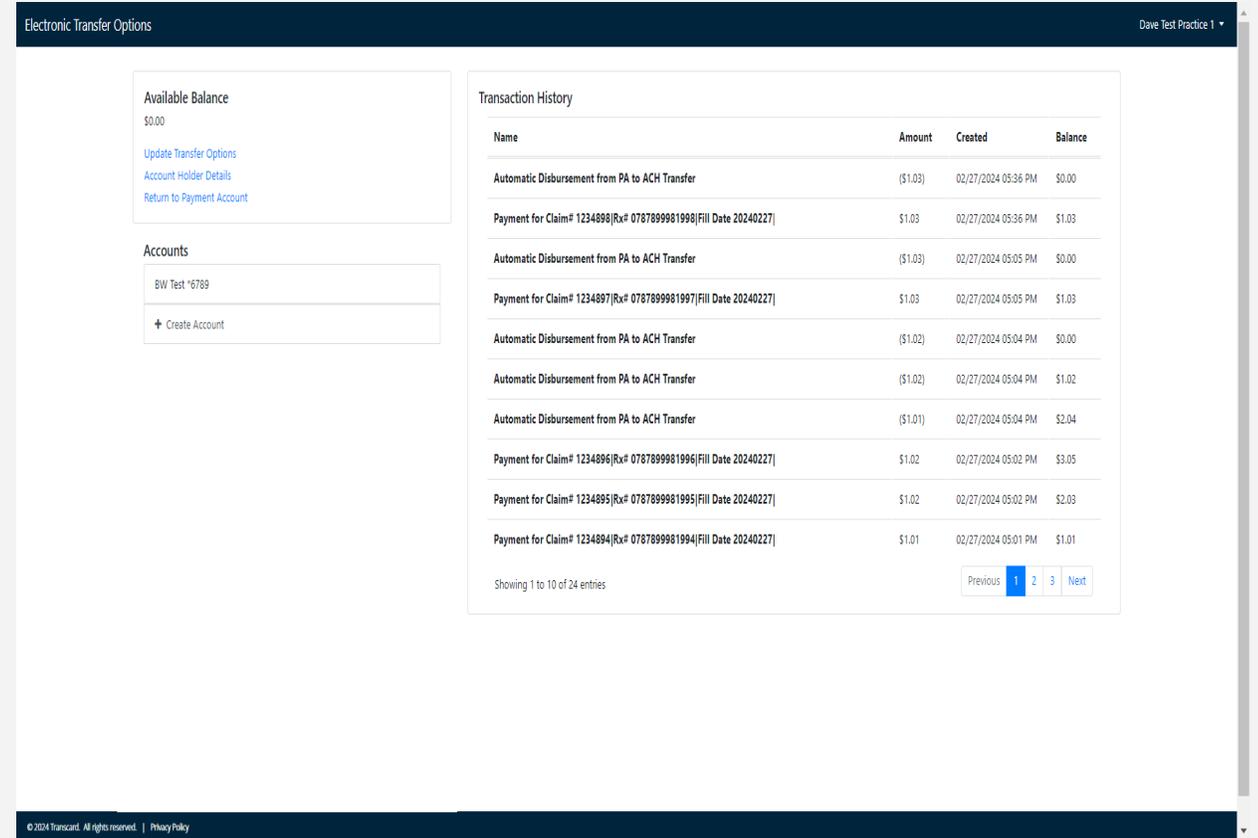
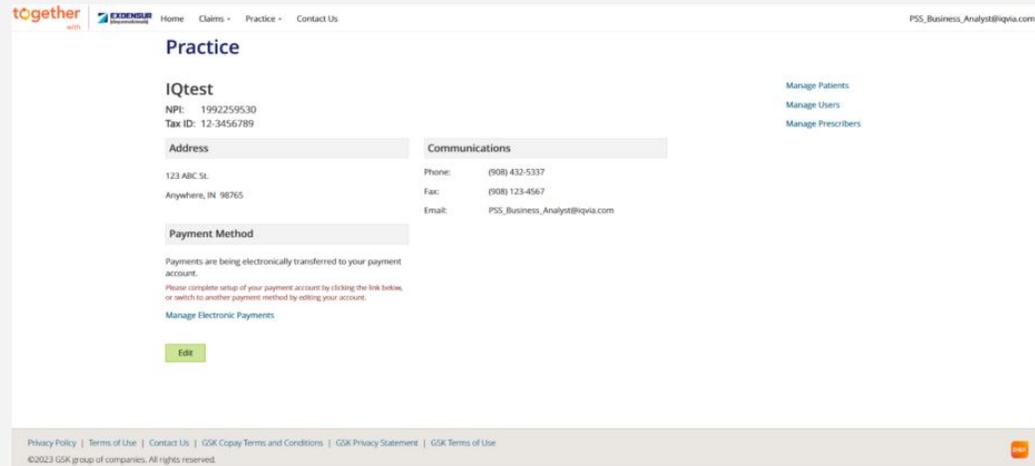
Download claim history

- As Excel
- As CSV

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Paynuver Guide

Once you have selected Manage Electronic Payments, the user will be automatically taken right into the Paynuver Microsite where they can view their EFT payment transaction history, update their transfer options, view the account holder details, create new accounts (banks account for deposits), and return to the payment account.



Paynuver Guide

Electronic Transfer Options Dave Test Practice 1

Available Balance
\$0.00

[Update Transfer Options](#)
[Account Holder Details](#)
[Return to Payment Account](#)

Accounts

BW Test *6789

+ Create Account

Transaction History

Name	Amount	Created	Balance
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:36 PM	\$0.00
Payment for Claim# 1234898[Rx# 0787899981998 Fill Date 20240227]	\$1.03	02/27/2024 05:36 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:05 PM	\$0.00
Payment for Claim# 1234897[Rx# 0787899981997 Fill Date 20240227]	\$1.03	02/27/2024 05:05 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$0.00
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$1.02
Automatic Disbursement from PA to ACH Transfer	(\$1.01)	02/27/2024 05:04 PM	\$2.04
Payment for Claim# 1234896[Rx# 0787899981996 Fill Date 20240227]	\$1.02	02/27/2024 05:02 PM	\$3.05
Payment for Claim# 1234895[Rx# 0787899981995 Fill Date 20240227]	\$1.02	02/27/2024 05:02 PM	\$2.03
Payment for Claim# 1234894[Rx# 0787899981994 Fill Date 20240227]	\$1.01	02/27/2024 05:01 PM	\$1.01

Showing 1 to 10 of 24 entries

Previous **1** 2 3 Next

- Current Transaction History displays as follows:
 - Claim# XXXXXXXXX|Rx# XXXXXXXXXXXXX|Fill Date XXXXXXXXX
- Enhancements to this page include:
 - Patient Name added to each transaction record.(will be displayed after the Fill Date)
 - The ability to export the Transaction History from the Paynuver Microsite

Paynuver Guide

Member ID Included in Transaction Details

First & Last Name | Member ID | RX# | Claim ID | Date Created | Prescription Fill Date | Claim Amount | Disbursement Type

TO THE ORDER OF:

Dave Test Practice 1



DATE:

January 15, 2025

Transaction Details: 1/1/2025 - 1/13/2025

Name Registered	Member ID	Prescription Number (RX#)	IQVIA Claim ID	Date Created	Prescription Fill Date	Claim Amount	Disbursement Type

For questions, call Customer Support (800) 555-4820

Paynuver Guide

Electronic Transfer Options

Dave Test Practice 1

Available Balance

\$0.00

[Update Transfer Options](#)

[Account Holder Details](#)

[Return to Payment Account](#)

Accounts

BW Test *6789

+ Create Account

Transaction History

Name	Amount	Created	Balance
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:36 PM	\$0.00
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Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:05 PM	\$0.00
Payment for Claim# 1234897[Rx# 0787899981997][Fill Date 20240227]	\$1.03	02/27/2024 05:05 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$0.00
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$1.02
Automatic Disbursement from PA to ACH Transfer	(\$1.01)	02/27/2024 05:04 PM	\$2.04
Payment for Claim# 1234896[Rx# 0787899981996][Fill Date 20240227]	\$1.02	02/27/2024 05:02 PM	\$3.05
Payment for Claim# 1234895[Rx# 0787899981995][Fill Date 20240227]	\$1.02	02/27/2024 05:02 PM	\$2.03
Payment for Claim# 1234894[Rx# 0787899981994][Fill Date 20240227]	\$1.01	02/27/2024 05:01 PM	\$1.01

Showing 1 to 10 of 24 entries

Previous 1 2 3 Next

Once finished in the Paynuver Microsite, select Return to Payment Account and the user will be brought back to the HCP Buy and Bill Portal Home Page

Thank You

