Benlysta Gateway

ENROLLMENT FORM

Please complete the form, sign, and FAX to 1-877-850-9901.
For assistance, please call 1-877-4-BENLYSTA (1-877-423-6597).

PATIENT SECTION

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

By signing below, **I agree** to allow my doctors, pharmacies, including my specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my health information to GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing BENLYSTA Gateway services, which may include the following activities:

1) Communicating with my Healthcare Providers about BENLYSTA Gateway prescription and medical condition;
2) Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for GSK's patient assistance and co-pay assistance programs;
3) Contacting my insurer, other potential funding sources, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds;
4) Contacting me to offer (and, if I am interested, provide) optional case management and/or educational services offered by healthcare professionals; and
5) Disclosing my information to third parties if required by law.

By signing this authorization, **I acknowledge** my understanding that:

- My Healthcare Providers will not and may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on whether I sign this Patient authorization.
- Certain Healthcare Providers, such as specialty pharmacies, may receive payment from GSK for disclosing my information to GSK as permitted by this authorization.
- Once information about me is released to GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent GSK from further disclosing my information. However, I understand that GSK has agreed to use or disclose information received only for the purposes described in this authorization or as required by law.
- This authorization will remain in effect for two (2) years after I sign it (unless a shorter period is required by state law) or for as long as I participate in the Benlysta Gateway Program, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to P.O. Box 222173, Charlotte, NC 28222-2173, but that such a revocation would end my eligibility to participate in the BENLYSTA Gateway program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date written revocation is received, but will not apply to the extent that they have already taken action in reliance on this authorization. After this authorization is revoked, I understand that information provided to GSK prior to the revocation may be disclosed within GSK to maintain records of my participation.

*The patient, or the patient's authorized representative, **MUST** sign this form to receive BENLYSTA Gateway services. If an authorized representative signs for the patient, please indicate relationship to the patient.*

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Services Requested (Check all that apply)
☐ Benefits Verification ☐ SP Triage ☐ Claims Assistance ☐ Co-pay Program
☐ Patient Assistance Program (PAP) for Uninsured Patient (see pg 3) ☐ Prior Authorization Assistance

PATIENT SECTION

Patient Information *Indicates required fields

Last name*: First name*:
Date of birth* (mm/dd/yy): City: State: Zip:
Street: Alternate contact name*:
Home phone: Work/cell phone: Alternate contact phone*:
E-mail: Alternate contact relationship to patient*:
Co-pay Program communication preference: ☐ Text ☐ E-mail ☐ Mail Only Language preference: ☐ English ☐ Spanish ☐ Mandarin ☐ Other:
Patient name or caregiver (print): Date:
Relationship to patient: ☐ BENLYSTACares Patient Support Program (see pg 3)

PATIENT TO SIGN

PATIENT SIGNATURE REQUIRED HERE
I have read and agree to the included HIPAA Patient Authorization form.

PATIENT SIGNATURE OPTIONAL HERE
I have read and agree to the BENLYSTACares Patient Support Program consent on page 3.

Insurance Information: Have you provided copies of all insurance cards? ☐ Medical Cards ☐ Prescription Card

Primary insurance*: Insurance type: ☐ Private Commercial ☐ Medicare/Medicaid ☐ TRICARE
Phone: Policy ID #: Group #:
Secondary insurance*: Insurance type: ☐ Private Commercial ☐ Medicare/Medicaid ☐ TRICARE
Phone: Policy ID #: Group #:
Rx Card (PBM): ID#:
BIN #: PCN #: Group #:
Policyholder last name: Policyholder first name: Policyholder relationship to patient:
Policyholder date of birth (mm/dd/yy): Employer:

PRESCRIBER SECTION

Prescriber, Acquisition, and Administration Information *Indicates required fields

Prescriber's last name*: Prescriber's first name*:
Practice name*: Specialty*:
Street*: City*: State*: Zip*:
Office contact name*: Phone*: Fax*:
Prescriber Tax ID*: Prescriber DEA #:
Prescriber State License #: Prescriber NPI #*: Group NPI #:
Are you the prescribing physician? ☐ Yes ☐ No If no, provide name of prescribing physician:
How will BENLYSTA be acquired? ☐ Buy and Bill ☐ Specialty Pharmacy ☐ Undecided
Site of Administration: ☐ Prescribing Physician's Office ☐ Other Physician's Office ☐ HOPD ☐ ASOC ☐ Patient administered

If administration site is different than site of prescribing physician, please complete the following:

Administering practice/facility: Administering office contact:
Street Address: City: State: Zip:
Phone: Fax: Administering site tax ID: Administering site NPI #:

Diagnosis and Clinical Information (Prescribed dosing regimen of BENLYSTA)

☐ BENLYSTA for intravenous use (IV) ☐ BENLYSTA for subcutaneous use (SC) Dose: Frequency: Date to begin dosing regimen:

It is up to the provider to determine the most appropriate diagnosis code. Consult the patient's payer for coding or documentation requirements.

Diagnosis ICD10 code*:	**Date of Diagnosis** (mm/dd/yy):
☐ M32.0 Systemic Lupus Erythematosus (SLE)	Anti-Nuclear Antibody (ANA):
☐ M32.8 Other forms of Systemic Lupus Erythematosus	Anti ds-DNA Level:
☐ M32.9 Systemic Lupus Emphysematous, unspecified	SELENA-SLEDAI Score: Patient Weight:
☐ Other:	☐ Medication Allergies:
☐ Concomitant Medications (please attach)	

Specialty Pharmacy Referral (Complete only if requesting that medication referral be triaged to Specialty Pharmacy)

☐ New ☐ Restart ☐ Continuing Last treatment date (mm/dd/yy): Next treatment date/Date needed by (mm/dd/yy):
If Specialty Pharmacy selected, has the prescription already been forwarded to a Specialty Pharmacy? ☐ No ☐ Yes–which one?
Specialty Pharmacy selection is subject to health plan requirements. Request Specialty Pharmacy for Triage? ☐ No ☐ Yes Preferred:
Specialty Pharmacy ship to: ☐Patient address (BENLYSTA SC only) ☐Prescribing physician's office ☐Administering physician's office ☐HOPD ☐ASOC

MEDICATION	STRENGTH/FORM	QTY	DIRECTIONS FOR ADMINISTRATION	REFILLS
BENLYSTA SC	200 mg in a 1-mL single dose autoinjector (box of 4)			
BENLYSTA SC	200 mg in a 1-mL single dose prefilled syringe (box of 4)			
BENLYSTA IV	120 mg in a 5-mL single-use vial			
BENLYSTA IV	400 mg in a 20-mL single-use vial			

Prescriber Declaration: I certify that the information provided above is true and that BENLYSTA 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 BENLYSTA would be collected from the patient upon treatment. I appoint the BENLYSTA 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.

PRESCRIBER TO SIGN

SUBSTITUTION PERMITTED (Date) **DISPENSE AS WRITTEN* (Date)**

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Patient Name: _____ **Date of Birth (mm/dd/yyyy):** _____

PATIENT SECTION

Optional: BENLYSTACares Patient Support Program

GSK offers helpful services and resources to support you on your treatment journey with BENLYSTACares.

GlaxoSmithKline (GSK) believes your privacy is important. By providing your name, address, phone number, email address, and other information, you are giving GSK and companies working with GSK permission to market or advertise to you across multiple channels, eg, mail, email, websites, online advertising, applications, and services, regarding the medical condition(s) in which you have expressed an interest, as well as other health-related information from GSK. GSK will not sell or transfer your name, address, or email address to any other party for their own marketing use. For additional information regarding how GSK handles your information, please see our privacy statement.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Patient Assistance Program (PAP)–Uninsured Patients

Uninsured patients who are prescribed BENLYSTA may be eligible for GSK's Patient Assistance Program (PAP). (Please note that this does not constitute health insurance.)
To find out if you qualify, please fill in the information below.

PATIENT TO COMPLETE

☐ **Enroll in PAP Program** **Annual pretax household income:** _____ **Number of family members living in household:** ____

PAP applicants are required to submit verification for all sources of household income at time of application, including a copy of one (1) of the following: most recent federal tax return, pay stub, W-2 statement, bank statement, or another source of income verification. This information will only be used to determine eligibility for the PAP. If you do not have one of the above-mentioned sources, please call 1-877-423-6597 for more information.

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