ENROLLMENT FORM

Benlysta Gateway

Please complete the form, sign, and fax to 1-877-850-9901. For assistance, please call 1-877-4-BENLYSTA (1-877-423-6597) M–F, 8 AM–8 PM ET.

Services Requested (Check all that apply)

- ☐ Benefits verification and prior authorization research
- ☐ Prior authorization follow-up and appeal support
- ☐ Co-pay Program
- ☐ Specialty pharmacy (SP) triage
- ☐ Patient Assistance Program (PAP)
- ☐ Claims and billing support

BENLYSTA Cares: Disease-specific education, patient support services, and other communication

Patient Information *Indicates required fields

Last name*:		First name*:	
Street*:			
City*:		State*:	Zip*:
Date of birth* (mm/dd/yyyy):	Gender:	Alternate contact name:	
Preferred phone #*:	☐ Home ☐ Mobile	Alternate contact phone:	
Language preference (if other than English):		Alternate contact relationship to patient:	

If requesting Co-pay Program, please select communication preference: ☐ Mail Only ☐ Text ☐ E-mail:

Patient or caregiver name (print):

Relationship to patient: Date:

PATIENT SIGNS TO AUTHORIZE

PATIENT SIGNATURE REQUIRED HERE

I have read and agree to the HIPAA Patient Authorization form (please see page 4).*

PATIENT SIGNS TO ENROLL

PATIENT SIGNATURE HERE

I have read and agree to the OPTIONAL BENLYSTA Cares Patient Support Program consent (please see page 5). If you have chosen to participate in the BENLYSTA Cares Program, please fill in your email above.

Insurance Information: Please provide front and back copies of all insurance cards.

☐ Private Commercial ☐ Medicare/Medicaid ☐ TRICARE ☐ No insurance

	Primary insurance	Secondary insurance	Pharmacy Insurance
Insurance provider			
Insurance Phone			
Cardholder name (if not the patient)			
Cardholder DOB			
Policy #			
Group #			
BIN/PCN	N/A	N/A	

Patient Assistance Program (PAP) (Patient to complete only if requesting PAP)

Uninsured patients who are prescribed BENLYSTA may be eligible for GSK's Patient Assistance Program (PAP). To find out if you qualify, please fill in the information below.

Annual pretax household income: Number of family members living in household:

PATIENT TO COMPLETE

Please note that this does not constitute health insurance. Applicants authorize the GSK PAP and its Administrators to obtain a consumer report. The consumer report, and the information derived from public and other sources, will be used to estimate income as part of the process to decide eligibility to receive free medication from GSK PAP. Upon request, GSK PAP will provide applicants with the name and address of the consumer reporting agency that provides the consumer report. The program may request additional documents and information at any time, even after enrollment, to determine if the information on the enrollment form is complete and true. Please note that Medicare applicants must also send proof that they have spent 3% of household income on prescription medications in the current calendar year for the applicant.

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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:	State license #:	
Prescriber NPI #*:		

Administration method (choose one)	Administration site	Acquisition method
☐ IV	→ Office administered only	→ ☐ Buy & bill ☐ Specialty pharmacy ☐ Undecided
☐ SC	→ Patient administered	→ Specialty pharmacy

☐ I would like to understand coverage for all administration methods.

Site of Care: Complete this section ONLY if the place of administration differs from the prescribing office.

Administering practice/facility:	Administering physician name:	
Street address:	City:	State: Zip:
Phone:	Fax:	
Tax ID:	NPI:	

Diagnosis and Clinical Information

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

Diagnosis ICD-10 code*:	**Date of diagnosis (mm/dd/yyyy):**
☐ M32.1 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:
☐ M32.14 Glomerular disease in systemic lupus erythematosus	☐ Medication allergies:
☐ M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus	☐ Concomitant medications (please attach)
☐ Other:	

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Patient name:	**Date of birth (mm/dd/yyyy):**

Prescriber, Acquisition, and Administration Information: Specialty Pharmacy Referral

(Complete only if requesting that medication referral be triaged to specialty pharmacy.)

NOTE: Specialty pharmacy selection is subject to health plan requirements.

☐ New ☐ Restart ☐ Continuing	Last treatment date (mm/dd/yyyy): Next treatment date/Date needed by (mm/dd/yyyy):

Has the prescription already been forwarded to a specialty pharmacy?

☐ No ☐ Yes—which one?

Specialty pharmacy ship to: ☐ Patient address ☐ Prescribing physician's office ☐ HOPD ☐ ASOC

Prescription

Prescriber to indicate preferred dosing regimen of BENLYSTA

MEDICATION		STRENGTH/FORM	DIRECTIONS FOR ADMINISTRATION (prescriber to fill in)	QTY	REFILLS
Office Administered (IV)					
BENLYSTA IV	☐	120 mg in a 5-mL single-use vial (NDC 49401-101-01); reconstitute with 1.5 mL Sterile Water for Injection, USP			
	☐	400 mg in a 20-mL single-use vial (NDC 49401-102-01); reconstitute with 4.8 mL Sterile Water for Injection, USP			
Patient Administered (SC)					
BENLYSTA SC	☐	200 mg in a 1-mL single dose autoinjector (box of 4; NDC 49401-088-35)			
	☐	200 mg in a 1-mL single dose prefilled syringe (box of 4; NDC 49401-088-47)			

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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ENROLLMENT FORM

Benlysta Gateway

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 my BENLYSTA 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 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 PO Box 221797, Charlotte, NC 28222-1797, 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.*

ENROLLMENT FORM

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BENLYSTA Gateway

The Gateway is here to:

- Help you understand your insurance coverage for BENLYSTA
- Enroll you in the Co-pay Program or PAP if eligible

What Happens Next?

1. In order to determine whether your insurer will cover your prescription, a Gateway representative will provide information about insurance coverage to you and your health care provider. Allow 2 business days for application processing.

2. Your benefits information will be sent to you by mail. This will tell you your insurance company's policies for covering BENLYSTA and estimate your out-of-pocket cost for BENLYSTA.

While you wait:

- Be on the lookout for a phone call from your specialty pharmacy or Gateway Representative (you may not recognize these numbers). Be sure to respond to any voice mails they leave. Not doing so could delay your treatment.
- If you do not hear from your doctor's office or specialty pharmacy within the next 2 weeks, contact your doctor's office to check on the progress.

Optional: BENLYSTA Cares Patient Support Program

3. If you enroll in the BENLYSTA Cares Patient Support Program, you will receive a variety of support materials about BENLYSTA and you will be contacted by a BENLYSTA Nurse to help you get started. Contact the BENLYSTA nurse support line at 1-877-BENLYSTA with any questions about the product.

Program consent:

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

GSK believes your privacy is important.

By providing your name, address, email address, and other information, you are giving GSK and companies working for or with GSK permission to contact you for marketing, market research, or advertising purposes, or to invite you to interact with GSK in other ways 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 at https://privacy.gsk.com/en-us/.

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.

If you have questions at ANY point in this process, call 1-877-4-BENLYSTA (1-877-423-6597) to talk to a representative. Representatives are available Monday–Friday, 8 AM–8 PM ET.