ENROLLMENT FORM

Please complete the form, sign, and FAX to: 1-877-850-9901

For assistance, please call: 1-877-423-6597
(Monday – Friday, 8AM to 8PM ET)

Benlysta Gateway

Scan to save contact information for BENLYSTA Gateway

BENLYSTA Gateway Services

- Benefits Verification and Prior Authorization Research
- Prior Authorization Follow-up and Appeal Support
- Co-pay Program **(commercial only)**
- Specialty Pharmacy (SP) Triage
- Patient Assistance Program (PAP)
- Claims and Billing Support
- **BENLYSTA Cares Support (Optional):** Disease-specific education, patient support services, and other communication

***Indicates required fields**

Patient Information

Last name*:		First name*:
Street*:		City*:
State*:	Zip*:	Email:
Date of birth* (mm/dd/yyyy):	Gender:	Language preference (if other than English):
Preferred phone #*:	☐ Home ☐ Mobile	Alternate contact name:
OK to leave a detailed voicemail? ☐ Yes		Home/Mobile:
Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening		Alternate contact phone:
		Alternate contact relationship to patient:

Enroll in Mobile Text Notifications (Optional):

☐ Opt-in (include mobile phone number above)

By opting into texting you authorize GSK and its service providers to contact you and send communications about your enrollment in BENLYSTA Gateway via telephone and text message. These calls or text messages may be generated using auto-dial or pre-recorded messages at the number you submit. The number and type of messages will be based upon your program selections, and message and data rates may apply. At any time, you may request to stop telephone calls or text messages by following the opt-out directions provided during those communications.

Print name: | Relationship to patient:

GATEWAY PATIENT AUTHORIZATION*

PATIENT SIGNATURE REQUIRED HERE | Date:

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

BENLYSTA CARES SUPPORT CONSENT

PATIENT SIGNATURE HERE | Date:

I have read and agree to the OPTIONAL BENLYSTA Cares Support consent (please see page 2).
If you have chosen to participate in the BENLYSTA Cares Program, please fill in your email on page 2.

*Insurance Information: Please provide front and back copies of all medical and prescription insurance cards

☐ 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	

Is a Prior Authorization on file with the Payer? ☐ Yes ☐ No | Authorization #: | Expiration Date:

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

Uninsured and eligible Medicare 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:
Medicare Beneficiary Identifier (MBI):	

PATIENT TO COMPLETE

Applicants authorize the GSK Specialty 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 the GSK Specialty PAP. Upon request, the GSK Specialty 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. Patients who participate or are enrolled in an Alternate Funding Plan are not eligible for GSK PAP. For additional questions about eligibility, please contact the BENLYSTA Gateway or GSKforYOU.com.

†The GSK Patient Assistance Program is operated by the GSK Patient Access Programs Foundation, an independent non-profit organization separate from GSK.

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Prescriber, Acquisition, and Administration Information: Prescriber signature required on all enrollment forms

Prescriber's last name*:	Prescriber's first name*:	
Practice name*:	Specialty:	
Street*:	City*:	State*: Zip*:
Office contact name*:		
Email:	Phone*: Ext:	Fax*:
Prescriber Tax ID*:	State license #*:	
Prescriber NPI #*:		

Administration Method (choose one)	Administration Site	Acquisition Method
☐ IV	→ Office administered only	☐ Buy & bill ☐ Specialty pharmacy
☐ SC	→ Patient administered	→ Specialty pharmacy

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: Ext:	Fax:	
Tax ID:	NPI:	

☐ Check here if Gateway support is needed to identify an appropriate Site of Care (infusion center)

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.

Please select ICD-10 Diagnosis Code and Description*:

☐ M32.1 Systemic lupus erythematosus (SLE)	☐ M32.14 Glomerular disease in systemic lupus erythematosus
☐ M32.8 Other forms of systemic lupus erythematosus	☐ M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus
☐ M32.9 Systemic lupus erythematosus, unspecified	☐ Other:

Optional: BENLYSTA Cares Support

BENLYSTA Cares offers patient services to help you begin and continue treatment with BENLYSTA. If enrolled, a healthcare professional* from the BENLYSTA Cares Nurse Support Line will call you. The Support Line will get you on your way by answering questions you may have about BENLYSTA.

Give them a call: 1-877-4-BENLYSTA (1-877-423-6597)

*BENLYSTA Cares personnel do not give medical advice. You will be directed to your healthcare provider for any disease, treatment, or referral-related questions.

BENLYSTA Cares Support Consent:

By providing your name, address, email address, and other information including your indication below 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.

My indication (select all that apply):

☐ Lupus ☐ Lupus nephritis

For additional information about how GSK handles your information, please see our privacy notice at https://privacy.gsk.com/en-us.

Email address:

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.

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

• Prescriber signature below is required for Rx and/or enrollment • 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?

☐ Do not triage the prescription to the specialty pharmacy

Prescription:
Prescriber to indicate preferred dosing regimen of BENLYSTA

MEDICATION		STRENGTH/FORM	QTY	REFILLS	DIRECTIONS FOR ADMINISTRATION (prescriber to fill in)
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	PRESCRIBER SIGNATURE HERE			
	SUBSTITUTION PERMITTED	**(Date)**	**DISPENSE AS WRITTEN***	**(Date)**

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

By signing this form, **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 GSK and to the GSK Patient Access Programs Foundation 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 or Patient Assistance Programs, 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 or the GSK Patient Assistance 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 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in the BENLYSTA Gateway and the GSK Patient Assistance 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.
- I understand that I, as the patient or signer, have a right to receive a copy of this signed form.

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