Together with GSK Oncology Enrollment Form

Fax completed enrollment form to 1-844-475-4662
For assistance, please call 1-844-4GSK-ONC
Monday-Friday (8 AM to 8 PM ET)

Together with GSK Oncology

BLENREP
belantamab mafodotin-blmf
for injection 100 mg

Important Instructions:

Complete pages 2 and 3 of the Together with GSK Oncology Enrollment Form.

Patient to sign and date section 4 on page 2.
Healthcare Professional to sign and date section 10 on page 3.
Fax the completed and signed enrollment form, plus copies of your patient's medical and pharmacy insurance cards, to 1-844-475-4662

Patient Information

Section 1: Select the services you are requesting.

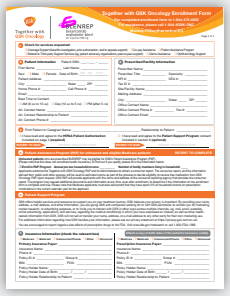
Section 2: Complete the Patient Information.

Section 4: Read HIPAA Patient Authorization on page 4, and check the box, sign, and date. Read section 6, and check the box for optional Patient Support Program.

Section 5: (optional): If you'd like to see if you're eligible for the Patient Assistance Program (PAP), check the box to enroll, and complete PAP Information to research eligibility.

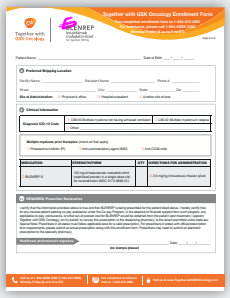
Next steps: Together with GSK Oncology will call patients within 2 business days to provide coverage information for their prescribed treatment and offer co-pay assistance options for eligible patients.

Prescriber Information



Section 3: Provide the Prescriber/Facility Information.

Section 7: Treatment may be covered under the medical or pharmacy benefit. Include legible copies (front and back) of the patient's medical and pharmacy insurance card(s). Include primary, secondary, Medicare/Medicaid (if eligible), and pharmacy benefit insurance information to ensure that ALL potential coverage options can be explored.



Section 8: Identify preferred shipping location if different than section 3.

Section 9: Clinical information is very important and often requested when verifying benefits. Diagnosis and appropriate ICD-10 code are required fields.

Section 10: Read Prescriber Declaration, sign, and date. A healthcare professional's signature is required.

Next steps: Together with GSK Oncology will confirm receipt by the next business day and conduct a summary of benefits call within 1-2 business days. Healthcare professionals will be notified regarding contact preferences and Together with GSK Oncology service options for patients.

Together with GSK Oncology Services:

- Benefits Investigation
- Prior Authorization and Appeals Support
- Commercial Co-pay Assistance Program
- Referrals to Patient Advocacy Organizations
- Ophthalmology Support
- Referrals to Independent Co-pay Foundations
- Patient Assistance Program (PAP)

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1 Check for services requested:

❍ Coverage Support (benefits investigation, prior authorization, and/or appeals support) ❍ Co-pay Assistance ❍ Patient Assistance Program
❍ Referral to Third-party Support Services (eg, patient advocacy organizations, peer-to-peer support) ❍ Claims Assistance ❍ Ophthalmology Support

2 Patient Information

Patient SSN: ____-____ - _____
First Name: _____ Last Name: _____
Sex: ❍ Male ❍ Female Date of Birth: MM DD YYYY
Patient Address: _____
City: _____ State: _____ ZIP: _____
Home Phone #: _____ Cell Phone #: _____
Email: _____
Best Time to Contact:
❍ AM (8 AM to 10 AM) ❍ Day (10 AM to 5 PM) ❍ PM (after 5 PM)
Alt. Contact Name: _____
Alt. Contact Relationship to Patient: _____
Alt. Contact Phone #: _____

3 Prescriber/Facility Information

Prescriber Name: _____
Prescriber Title: _____ Specialty: _____
NPI #: _____ DEA #: _____
Tax ID #: _____
Site/Facility Name: _____
Mailing Address: _____
City: _____ State: _____ ZIP: _____
Office Contact Name: _____
Office Contact Phone #: _____ Fax #: _____
Office Contact Email: _____

4

Print Patient or Caregiver Name: _____ Relationship to Patient: _____

❍ I have read and agree to the **HIPAA Patient Authorization** included on page 4 **(required)**

PATIENT TO SIGN PATIENT SIGNATURE HERE

❍ I have read and agree to the **Patient Support Program** consent included in section 6 **(optional)**

PATIENT TO SIGN PATIENT SIGNATURE HERE

5 Patient Assistance Program (PAP) for uninsured and eligible Medicare patients — PATIENT TO COMPLETE

Uninsured patients who are prescribed BLENREP 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.

❍ **Enroll in PAP Program** **Annual pre-tax household income:** _____ **Number of family members living in household:** ____

Applicants authorize the Together with GSK Oncology 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 Oncology 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.

6 Patient Support Program

GSK offers helpful services and resources to support you on your treatment journey. GSK believes your privacy is important. By providing your name, address, e-mail 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 e-mail 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.

7 Insurance Information (check the relevant box)

❍ **Medicare** ❍ **Medicaid** ❍ **Commercial/Private** ❍ **Other** ❍ **Uninsured**

Primary Insurance Payer: _____
Insurance Name: _____
Phone #: _____
Policy ID #: _____ Group #: _____
BIN: _____ PCN: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____ / _____ / _____
Policy Holder Relationship to Patient: _____

Attach a copy of both sides of the patient's insurance card(s).

❍ **Medicare** ❍ **Medicaid** ❍ **Commercial/Private** ❍ **Other** ❍ **Uninsured**

Prescription Insurance Payer: _____
Insurance Name: _____
Phone #: _____
Policy ID #: _____ Group #: _____
BIN: _____ PCN: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____ / _____ / _____
Policy Holder Relationship to Patient: _____

Patient Name: _____ Date of Birth: ____ / _____ / _____

8 Preferred Shipping Location

Facility Name: _____ Recipient Name: _____ Phone #: _____

Street: _____ City: _____ State: _____ Zip: _____

Site of Administration: ❍ Physician's office ❍ Hospital outpatient ❍ Another site of care

9 Clinical Information

Diagnosis ICD-10 Code	❍ C90.00-Multiple myeloma not having achieved remission	❍ C90.02-Multiple myeloma in relapse
	❍ Other: _____	

Multiple myeloma prior therapies: (check all that apply)

❍ Proteasome inhibitor (PI) ❍ Immunomodulatory agent (IMiD) ❍ Anti-CD38 mAb

MEDICATION	STRENGTH/FORM	QTY	DIRECTIONS FOR ADMINISTRATION
❍ BLENREP IV	100 mg of belantamab mafodotin-blmf lyophilized powder in a single-dose vial for reconstitution (NDC 0173-0896-01)		❍ 2.5 mg/kg intravenous infusion q3wk

10 REQUIRED: Prescriber Declaration

I certify that the information provided above is true and that BLENREP 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 BLENREP would be collected from the patient upon treatment. I appoint Together with GSK Oncology, 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.

Healthcare professional's signature _____ Date: _____/_____/_____

(no stamps please)

Together with GSK Oncology

BLENREP
belantamab mafodotin-blmf
for injection 100 mg

REQUIRED: HIPAA Patient Authorization

By signing this form on page 2, **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 its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing Together with GSK Oncology services, which may include the following activities:

1. Communicating with my Healthcare Providers about my BLENREP prescription and medical condition;
2. Providing ophthalmology support, including ophthalmologist referral information and appointment reminders;
3. Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for GSK's patient assistance and co-pay assistance programs;
4. 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;
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, or 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 Together with GSK Oncology 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 **Together with GSK Oncology, P.O. Box 220664, Charlotte NC 28222**, but such a revocation would end my eligibility to participate in the Together with GSK Oncology program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date a 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 (section 4) in order for the patient to receive Together with GSK Oncology services. If an authorized representative signs for the patient, please indicate relationship to the patient.

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