Together with GSK Enrollment Form

Fax completed enrollment form to 1-844-760-0940
For assistance, please call 1-844-4GSK-ONC (1-844-447-5662)
Monday-Friday (8 AM to 8 PM ET)

together with | BLENREP belantamab mafodotin-blmf for injection

Visit us at www.TogetherwithGSK.com

An electronic Enrollment Form is available online. Scan the QR code to access Together with GSK.

Program services include:

- Coverage
- Eye Care Support
- Patient Assistance Program*
- Copay Assistance Program
- Disease State and Product Education
- Community Resource Information

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

Patient Information

*Indicates required fields.

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

Enroll in Mobile Text Notifications (Optional):

☐ *Opt-in (include mobile phone number above)*

By providing your phone number and checking this box you are opting in to receive SMS alerts from Together with GSK. These text messages may be generated using auto-dial at the number you submit. Message frequency varies. Text HELP to 29058 for help and STOP to opt out; message and data rates may apply. Refer to the Terms and Conditions and Privacy notice below or attached to the first text message. Visit https://togetherwithgsk.com/terms-and-conditions/ and https://privacy.gsk.com/en-us/privacy-notice/ for more information.

Insurance Information (Please provide front and back copies of all insurance cards)

○ No Insurance	Primary Insurance	Secondary Insurance
Insurance provider		
Insurance phone		
Cardholder name (if not the patient)		
Cardholder DOB		
Policy #		
Group #		

Patient Authorization (REQUIRED) and Marketing Opt-In Consent (Optional)

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 _____ Date (mm/dd/yyyy): _____

I have read and agree to the Marketing Opt-in consent included on page 2 (optional)

PATIENT TO SIGN — PATIENT SIGNATURE HERE _____ Date (mm/dd/yyyy): _____

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

Eye Care Professional (ECP) Information (complete if known)

ECP name:	Phone:		
Site/facility name:	Fax:		
Street:	City:	State:	Zip:

Eye Drop Supportive Care Program (Optional, eligible patients can receive preservative-free lubricant eye drops)

○ Yes, I would like to participate in the eye drop supportive care program	By opting in, I agree that GSK can use information about my continued use of BLENREP to provide me free preservative-free lubricant eye drops.

Patient Assistance Program* (PAP) for Uninsured and Eligible Medicare Patients (Optional)

Uninsured and underinsured 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.

Medicare patients applying for the PAP must provide their Medicare Beneficiary Identifier (MBI) found on their government-issued Medicare Health Insurance Card. It is 11 characters made up of letters and numbers (eg, 1EG4-TE5-MK73)

Medicare Beneficiary Identifier (MBI): _____

○ Enroll in PAP

Annual pre-tax household income: _____ Number of family members living in household: _____

Applicants authorize the Together with 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. 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 program or GSKPAF.org.

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Marketing Opt-in (Optional)

GSK offers helpful services and resources that help you begin and continue treatment with BLENREP. GSK believes your privacy is important. 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.

BLENREP indication: (check all that apply)

○ Multiple myeloma not having achieved remission ○ Multiple myeloma in relapse

For additional information regarding how GSK handles your information, please see our privacy notice 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.

Email address: _____

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

Prescriber/Site Information (REQUIRED)

*Indicates required fields.

Prescriber last name*:	First name*:	Specialty:	
Tax ID#*:	NPI#*:	State license#*:	
Practice name*:			
Street*:	City*:	State*:	Zip*:
Office contact name*:	Phone*:	Ext*:	
Office contact email*:	Fax*:		

Infusion Site (Optional, complete this section ONLY if site of administration differs from the prescribing site)

Facility name:		Phone:	
Street:	City:	State:	Zip:
Office contact email:		Fax:	

Clinical Information

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

Prescription

MEDICATION	STRENGTH/FORM	QTY	WEIGHT	REGIMEN
BLENREP IV	70 mg belantamab mafodotin-blmf as a lyophilized powder in a single-dose vial for reconstitution and further dilution		kg	○ With bortezomib and dexamethasone BLENREP 2.5 mg/kg as an intravenous infusion over approximately 30 minutes once every 3 weeks for 8 cycles, followed by BLENREP 2.5 mg/kg every 3 weeks as a single agent
				○ Other:

REQUIRED: Prescriber Declaration

I certify that the information provided above is true and that BLENREP is being prescribed for the patient listed above. I further certify that I have made an independent clinical judgment that BLENREP is medically necessary for the above-named patient. 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, 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 _____ Date (mm/dd/yyyy): _____

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

By signing this form on page 1, I authorize to allow my doctors, pharmacies, including my Specialty Pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my health information (my "Information") to GlaxoSmithKline and to the GSK Patient Access Programs Foundation and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and share my Information for purposes of providing Together with GSK or Patient Assistance Programs, which may include the following activities:

1. Communicating with my Healthcare Providers about my BLENREP 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 copay 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. Disclosing my information to third parties if required by law;
5. Sending me educational information about BLENREP and contacting me to describe (and, if I am interested, to provide) optional educational services offered by healthcare professionals; and
6. If I sign the BLENREP marketing consent on page 1 of this form, sending me promotional information as described in the Marketing Opt-In paragraph on page 2 of this form.

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

- My Healthcare Providers may not condition my treatment, payment for treatment, or eligibility for or enrollment in benefits on my signing 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 my Information is released to GSK based on this authorization, federal privacy laws may no longer protect the Information from re-disclosure. However, I also understand that GSK intends to share my Information only as described in this authorization or as otherwise permitted by law.
- This authorization will remain in effect for two (2) years after I sign it or for as long as I participate in Together with GSK or the GSK Patient Assistance Program, whichever is longer, subject to any applicable state law requirement for the authorization to expire.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to **Together with GSK, 2250 Perimeter Park Drive, Ste. 300, Morrisville, NC 27560**. Such a revocation will invalidate reliance on the authorization to use or disclose my Information, but will not invalidate any uses or disclosures made prior to the date my written statement of revocation is received. I understand that, even if I revoke the authorization, GSK may maintain my Information as part of records of my participation in Together with GSK and GSK Patient Assistance Program.
- I understand that I, as the patient or a legal representative signing on behalf of the patient, have a right to receive a copy of this signed form.

The patient, or the patient's authorized representative, MUST sign this form (page 1) in order for the patient to receive Together with GSK or GSK Patient Assistance Program services. If an authorized representative signs for the patient, please indicate relationship to the patient.

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GSK