# Services Form

Please complete the form, sign, and **FAX back both pages to 1-877-850-9901.**
For assistance with any questions, call 1-877-4-BENLYSTA (1-877-423-6597), Monday through Friday from 8 AM to 8 PM Eastern Time.

## SERVICES REQUESTED (Check all that apply)

☐ Benefits Verification
☐ Patient Assistance Program (PAP) for Uninsured Patient
☐ Co-Pay Program
☐ Claims Assistance
☐ Prior Authorization Assistance

## PATIENT INFORMATION

Last name:
First name:
Date of birth:
Gender: ☐ Female ☐ Male
Street:
City: State: ZIP:
Primary phone: ( )
Secondary phone: ( )
E-mail:
Alternate contact last name:
Alternate contact first name:
Alternate contact phone: ( )
Relationship to patient:

## INSURANCE INFORMATION (Please attach copy of insurance card[s])

| PRIMARY insurance name: | SECONDARY insurance name: |
|---|---|
| Phone: ( ) | Phone: ( ) |
| Policy ID #: | Policy ID #: |
| Group #: | Group #: |
| Policyholder name: | Policyholder name: |
| Policyholder date of birth: | Policyholder date of birth: |
| Relationship to patient: | Relationship to patient: |

## DIAGNOSIS AND TREATMENT (Prescribed dosing regimen of BENLYSTA)

Dose: Frequency: Date to begin dosing regimen:
Patient diagnosis and ICD-9/ICD-10 (not required for uninsured PAP applicants):

## PHYSICIAN INFORMATION

Prescriber's last name:
Prescriber's first name:
Practice name:
Specialty:
Address:
City: State: ZIP:
Office contact name:
Phone: ( ) Fax: ( )
Prescriber tax ID:
Prescriber NPI #: Group NPI #:
Prescriber state license # (for uninsured PAP applicants only):
Are you the prescribing physician? ☐ Yes ☐ No If no, provide name of prescribing physician:
Site of administration: ☐ Prescribing physician's office ☐ Other physician's office ☐ Hospital outpatient ☐ Other:

**If administration site is different from site of prescribing physician, please complete the following.**

Administering practice/facility name:
Administering physician's last name:
Administering physician's first name:
Street:
City: State: ZIP:
Administering office contact:
Phone: ( ) Fax: ( )
Administering site tax ID:
Administering site NPI #:

## SPECIALTY PHARMACY

Are you interested in acquiring medication through a specialty pharmacy? ☐ Yes ☐ No
If yes, please list any preferred specialty pharmacies:

## PRESCRIBER DECLARATION

I certify that BENLYSTA is being prescribed for the patient listed above. I have supplied the program operated by the Lash Group, an agent of GSK, this information in order for them to coordinate access to treatment for my patient. I hereby certify that, for any insured patient seeking co-pay assistance under the BENLYSTA® Co-Pay Assistance 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.

**PRESCRIBER SIGN HERE**

**Prescriber signature:**

**Name (print):** **Date:**

Benlysta® Gateway
(belimumab)

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**REQUIRED: TO BE FILLED OUT BY THE PATIENT**

## PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I verify that the information provided herein is true and correct. I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, and medical information, is "protected health information." By signing below, I agree to the collection, use, and disclosure of my protected health information as described below. I understand that my healthcare providers will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release. I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to use or disclose information received only for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for two (2) years or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer. I also understand that I have the right to revoke this authorization at any time by calling (877) 423-6597 or mailing a signed written statement of my revocation to PO Box 222173, Charlotte, NC 28222-2173, but that such a revocation would end my eligibility to participate in the programs as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that, after you revoke this authorization, your information may be disclosed among GSK and the company or companies that help GSK administer the programs in order to maintain records of your participation, but it will not be otherwise disclosed or used.

**Enrollment in BENLYSTA® (belimumab) Gateway (for reimbursement support and patient assistance):** The patient, or the patient's authorized representative, MUST sign this form in order to receive reimbursement support and assistance from the BENLYSTA Gateway. Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release. If an authorized representative signs for the patient, please indicate relationship to the patient. By signing below, I authorize GSK, as well as its agents and assignees and any other companies that GSK uses to administer reimbursement services for BENLYSTA, to do the following:

1) Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve my insurance coverage, coding, or reimbursement inquiry, or to review my eligibility for patient assistance programs and co-pay assistance;
2) Collect, use, and disclose to each other any information that I provide to BENLYSTA Gateway for the purpose of investigating and resolving my insurance coverage, coding, or reimbursement inquiry;
3) Disclose to my treating physician, healthcare provider, or pharmacist information I provided to BENLYSTA Gateway when necessary to resolve my insurance coverage, coding, or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by GSK, and the BENLYSTA Gateway;
4) Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and/or patient assistance programs on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information about my prescribed medications and medical condition that has been provided by me or my physician, healthcare provider, or pharmacist; and
5) Disclose any information obtained from the sources listed above to third parties if required by law.

**Patient or legal guardian signature:** PATIENT SIGN HERE

**Name (print):** **Date:**

## 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 if you qualify, please fill in the information below.

| | |
|---|---|
| **Annual pre-tax household income:** | **$** |
| **Number of family members living in household:** | |

PATIENT COMPLETE

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 be used only 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.

## RECEIVE EDUCATIONAL SUPPORT

Simply check the box below to receive ongoing support, tips, tools, stories and more from patients like you receiving BENLYSTA. (Optional)

☐ **By checking this box, I certify I am at least 18 years old and that I am giving GSK and companies working with GSK permission to market or advertise to me about BENLYSTA.** PATIENT CHECK HERE

**E-mail address:**

GSK believes your privacy is important. By providing your name, address, e-mail address, and other information, you are giving GSK and companies working with GSK permission to market or advertise to you regarding the medical condition(s) in which you have expressed an interest, as well as other general health-related information from GSK. GSK will not sell or transfer your name, address, or e-mail address to any other party for its own marketing use.

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