BLENREP Eye Drop Supportive Care Program

This form must be completed, signed, and submitted before you can receive preservative-free lubricant eye drops. Print and submit the completed form by fax at 1-888-635-1044.

BLENREP
belantamab mafodotin-blmf
for injection 100 mg

Patient Information

Fields marked * are REQUIRED

First Name*:	**Middle Initial:**	**Last Name*:**
Date of Birth (MM/DD/YYYY)*:	**Phone Number*:**	**Email Address:**
Address*:		
City*:	**State*:**	**ZIP Code:**
☐ **Shipping address is same as mailing address (above).** ☐ **Preferred shipping address entered below.**		
Preferred Shipping Address:		
City:	**State:**	**ZIP Code:**

Patient Authorization to Use Health Information

By signing this form, **I agree** to allow my doctors, doctors' offices, hospitals, infusion sites, specialty distributor(s), and authorized staff supporting these entities (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 me with preservative-free lubricant eye drops. The following activities are included:

1. Utilizing my REMS information such as REMS ID, REMS Enrollment Status, REMS Enrollment Form, Patient Status Forms, Eye Care Professional Consult Forms, and the REMS Checklist completed by my Healthcare Providers.
2. Communicating with my Healthcare Providers about my BLENREP prescription and medical condition.
3. Disclosing my information to third parties if required by law.

Continued on reverse.

Patient Authorization to Use Health Information *(cont'd)*

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.
- 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 eye drop 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 United BioSource LLC, BLENREP Eye Drop Supportive Care Program, 200 Pinecrest Plaza, Morgantown, WV 26505 US, but such a revocation would end my eligibility to participate in the eye drop program. (The revocation process may also be initiated by calling the Coordinating Center at 1-855-209-9188). 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 legal guardian, **MUST** *sign this form in order for the patient to receive preservative-free lubricant eye drops. If a legal guardian signs for the patient, please indicate relationship to the patient.*

Patient Signature and Acknowledgment

By signing this form, I agree that GSK can utilize the health information described above, including my REMS information, to provide me free preservative-free lubricant eye drops.

Patient / Legal Guardian Signature _____

PRINT NAME _____ Date _____
MONTH/DAY/YEAR

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