BLENREP
belantamab mafodotin-blmf
for injection 70 mg

BLENREP REMS
Patient Enrollment Form

This form must be completed before a patient can receive BLENREP.

Your prescriber will help you complete this form and will submit the form online at www.BLENREPREMS.com or by fax to the BLENREP REMS at 1-888-635-1044.

(Fields marked with an * are REQUIRED)

Patient Information

*First Name	Middle Initial	*Last Name	Suffix

*Date of Birth (MM/DD/YYYY)

*Address

*City	*State	*ZIP Code

*Phone	Email

Preferred Method of Contact ☐ Phone ☐ Email

Secondary Contact Name	Phone for Secondary Contact

Prescriber Information

*First Name	*Last Name

*National Provider Identifier (NPI)#	*Office Phone Number

Patient Agreement

Before I start treatment, I must:

- Review the **Patient Guide**.
- Receive counseling from my healthcare provider on the risk of eye problems and the need for eye exams using the **Patient Guide**.
- Enroll in the REMS by completing the **Patient Enrollment Form** with my healthcare provider.
- Get an eye exam.

During treatment; before each dose, I must:

- Get an eye exam.

At all times, I must:

- Inform my healthcare provider right away of any new or worsening eye symptoms or vision changes.
- Get eye exams as needed for any new or worsening eye problems, as described in the **Patient Guide**.

I understand that the BLENREP REMS and its agents or contractors may use and share my personal information to enroll me into and manage the BLENREP REMS. Information about all patients who get BLENREP will be stored in a private and secure database. My health information may be shared with the Food and Drug Administration (FDA) to evaluate the BLENREP REMS. However, my name will not be shared.

I give permission for GSK, LLC and its agents to contact me or my prescriber by phone, mail, or email to manage the BLENREP REMS.

If patient/ legal guardian is unable to sign

Patient Verbal Attestation

If the patient/legal guardian is unable to sign this form, a verbal acknowledgement may be provided to the prescriber and/or prescriber designee by checking the box below indicating the patient has provided verbal attestation.

*☐ Patient/legal guardian is unable to sign this form; verbal patient acknowledgement has been provided to the prescriber and/or prescriber designee.

***Date of Verbal Attestation** ______________________
MM/DD/YYYY

—OR—

If patient/ legal guardian is able to sign

Patient Acknowledgement

If the patient/legal guardian is able to sign this form, please sign and date below. By signing this form, I agree BLENREP is only available through the BLENREP REMS and I must comply with the REMS requirements.

*Patient/Legal Guardian Signature	*Date MM/DD/YYYY

Prescriber Acknowledgement

I have informed the patient of the risk of ocular toxicity associated with BLENREP and the need for monitoring via ophthalmic exams during treatment.

*Prescriber Signature	*Date MM/DD/YYYY

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