

BLNREP™ REMS Healthcare Setting Enrollment Form



Submit the completed Form:

- Go to www.BLENREPREMS.com to login and complete this form online. If online capabilities are not available this form can be completed and faxed to the BLENREP REMS at 1-888-635-1044.

(Fields marked with an * are REQUIRED)

Healthcare Setting Information		
Healthcare Setting Name*:		
National Provider Identifier (NPI)#*:	HIN:	DEA#:
Site Type*: <input type="checkbox"/> Infusion Center <input type="checkbox"/> Group Practice <input type="checkbox"/> Independent Practice <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other (please specify) _____		
Address*:		
City*:	State*:	ZIP Code*:
Phone*:	Fax*:	
Ship To Information		
Ship To Address <input type="checkbox"/> Same as above	Ship To Contact Name*:	
Address*:		
City*:	State*:	ZIP Code*:
Phone:	Fax:	
Authorized Representative Information		
First Name*:	Last Name*:	
Credentials*: <input type="checkbox"/> DO <input type="checkbox"/> MD <input type="checkbox"/> PharmD <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other (please specify)		
National Provider Identifier (NPI)#:		
Phone*:	Fax*:	Email*:
Healthcare Setting Agreement:		
<p>As the Authorized Representative:</p> <ul style="list-style-type: none"> • I have reviewed the drug's Prescribing Information. • I have reviewed the <i>Program Overview and Education Program for Healthcare Settings</i>. • I must train all relevant staff involved in dispensing and administering BLENREP using the <i>Program Overview and Education Program for Healthcare Settings</i>. • I must establish processes and procedures to ensure the <i>REMS Checklist</i> is completed and submitted for each patient. <p>On behalf of the healthcare setting, I must comply with the following REMS requirements:</p> <p>Before administering each dose:</p> <ul style="list-style-type: none"> • Obtain authorization to dispense each dose by contacting the BLENREP REMS to verify <ul style="list-style-type: none"> - The prescriber is certified in the BLENREP REMS - The patient is enrolled in the BLENREP REMS and authorized to receive this dose of BLENREP • Complete the <i>REMS Checklist</i> <p>After administering BLENREP, within 5 business days:</p> <ul style="list-style-type: none"> • Submit the <i>REMS Checklist</i> to the BLENREP REMS. <p>At all times:</p> <ul style="list-style-type: none"> • Not distribute, transfer, loan or sell BLENREP. • Maintain records documenting staff completion of REMS training. • Maintain records that all processes and procedures are in place and are being followed. • Comply with audits carried out by GlaxoSmithKline or third party acting on GlaxoSmithKline's behalf to ensure that all processes and procedures are in place and are being followed. 		
By signing this form, I agree BLENREP is only available through the BLENREP REMS and I must comply with the REMS Requirements.		
Authorized Representative Signature*: _____		Date*: _____
PRINT NAME: _____		Month/Day/Year



Use this section to add each additional Healthcare Setting location for which the same Authorized Representative will be responsible.

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Ship To Address <input type="checkbox"/> Same as above	Ship To Contact Name*:	
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Ship To Information		
Ship To Address <input type="checkbox"/> Same as above	Ship To Contact Name*:	
Address*:		
City*:	State*:	ZIP Code*:
Phone:	Fax:	

Use this section to request portal access for Healthcare Setting staff that are trained and authorized to use the BLENREP REMS portal to generate authorization codes prior to dispensing and submit *REMS Checklists*.

(Fields marked with an * are REQUIRED)

User Access Form. Please Print clearly.

Healthcare Setting Name*:	First Name*:	Last Name*:	Credentials*:	Email*: