

# BLNREP™ REMS Prescriber Enrollment Form



To become a certified prescriber in the BLNREP REMS and prescribe BLNREP:

1. Review the BLNREP *Prescribing Information*
2. Review the *REMS Program Overview and Education Program for Prescribers*
3. Successfully complete and submit the *Knowledge Assessment* to the BLNREP REMS
4. Enroll in the BLNREP REMS by completing and submitting this *Prescriber Enrollment Form*

## Submit the completed Prescriber Enrollment Form:

- Go to [www.BLNREPREMS.com](http://www.BLNREPREMS.com) to login and complete this form online. If online capabilities are not available this form can be completed and faxed to the BLNREP REMS at 1-888-635-1044.

(Fields marked with an \* are REQUIRED)

| Prescriber Information   |                 |   |            |
|--|-----------------|---|------------|
| First Name*:   | Middle Initial: | Last Name*:   |            |
| Credentials*:<br><input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other (please specify) _____ |                 |   |            |
| Specialty*:<br><input type="checkbox"/> Oncology <input type="checkbox"/> Hematology <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Other (please specify) _____  |                 |   |            |
| National Provider Identifier (NPI) #*:   |                 | State License #:  |            |
| Practice/Facility Name*:   |                 |   |            |
| Address*:  |                 |   |            |
| City*:   |                 | State*:   | ZIP Code*: |
| Phone*:  | Fax*:           | Email*:   |            |
| Preferred Method of Communication:<br>(please select one) <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email                                   |                 | Preferred Time of Contact:<br><input type="checkbox"/> AM <input type="checkbox"/> PM |            |
| Prescriber Delegate Information  |                 |   |            |
| Note: If you want to add a delegate, the first name, last name and email are required fields. If you have any questions, please reach out to the BLNREP REMS at 1-855-209-9188.        |                 |   |            |
| First Name*  | Last Name*:     | Email*:   |            |
| <input type="checkbox"/> Address – Same as Prescriber  |                 |   |            |
| Address:   | City:           | State:  | ZIP Code:  |
| Phone:   | Fax:            |   |            |
| Alternative Practice/Facility Location   |                 |   |            |
| Address:   |                 |   |            |
| City:  | State:          | ZIP Code:   |            |



# BLENREP™ REMS Prescriber Enrollment Form (continued)

## Prescriber Responsibilities

### I have:

- Reviewed the drug's **Prescribing Information**.
- Reviewed the *Program Overview and Education Program for Prescribers*.
- Successfully completed the *Knowledge Assessment* and submitted it to the BLENREP REMS.

### Before treatment initiation (first dose), I must:

- Counsel the patient, using the *Patient Guide*, on
  - the risk of ocular toxicity associated with BLENREP and
  - requirement for monitoring via ophthalmic examinations (e.g., visual acuity and slit lamp) at
    - baseline,
    - prior to each dose, and
    - promptly for worsening symptoms
- Enroll the patient by completing and submitting the *Patient Enrollment Form* to the BLENREP REMS.
- Assess the patient's ocular health by consulting an eye care professional to complete the visual acuity and slit lamp examinations using the *Eye Care Professional Consult Request Form* or equivalent.
- Assess the patient's ophthalmic consult results for appropriateness of initiating treatment. Document and submit to the BLENREP REMS using the *Patient Status Form*.

### Before each infusion, I must

- Assess the patient's ocular health by consulting an eye care professional to complete visual acuity and slit lamp examinations using the *Eye Care Professional Consult Request Form* or equivalent.
- Assess the patient's ophthalmic consult results for appropriateness of continuing treatment. Document and submit to the BLENREP REMS using the *Patient Status Form*.

I understand that if I do not maintain compliance with the requirements of the BLENREP REMS, I will no longer be able to prescribe BLENREP.

I understand the BLENREP REMS may contact me via phone, mail, or email to discuss and/or to survey me on the effectiveness of the REMS requirements.

By signing this form, I agree BLENREP is only available through the BLENREP REMS and I must comply with the REMS Requirements.

**Prescriber Signature\*:** \_\_\_\_\_ **Date\*:** \_\_\_\_\_

Month/Day/Year

Print Name\*: \_\_\_\_\_