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)#*:

Site Type*:

- Infusion Center
- Group Practice
- Independent Practice
- Outpatient Clinic
- Hospital
- Other (please specify)

Address*:

City*:

State*:

ZIP Code*:

Phone*:

Fax*:

Ship To Information

Ship To Address:

Same as above

Ship To Contact Name*:

Address*:

City*:

State*:

ZIP Code*:

Phone:

Fax:

Authorized Representative Information

First Name*:

Last Name*:

Credentials*:

- DO
- MD
- PharmD
- RN
- NP
- PA
- Other (please specify)

National Provider Identifier (NPI)#:

Phone*:

Fax*:

Email*:

Healthcare Setting Agreement:

As the Authorized Representative:

• I have reviewed the drug’s Prescribing Information.
• I have reviewed the Program Overview and Education Program for Healthcare Settings.
• I must train all relevant staff involved in dispensing and administering BLENREP using the Program Overview and Education Program for Healthcare Settings.
• I must establish processes and procedures to ensure the REMS Checklist is completed and submitted for each patient.

On behalf of the healthcare setting, I must comply with the following REMS requirements:

Before administering each dose:

• Obtain authorization to dispense each dose by contacting the BLENREP REMS to verify
  - 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 REMS Checklist

After administering BLENREP, within 5 business days:

• Submit the REMS Checklist to the BLENREP REMS.

At all times:

• 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

GSK Final (08/2020)
Use this section to add each additional Healthcare Setting location for which the same Authorized Representative will be responsible.

(Fields marked with an * are REQUIRED)

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BLENREP™ REMS Healthcare Setting Enrollment Form

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.

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