Before I start treatment, I must
• Receive counseling from my prescriber using the Patient Guide.
• Enroll in the BLENREP REMS by completing the Patient Enrollment Form with my prescriber.
• Get an eye exam.

During my treatment and before each infusion, I must
• Get an eye exam.

At all times
• I must inform my prescriber if I have any signs or symptoms of worsening eyesight or eye health including:
  - Blurry vision
  - Dry eyes
  - Worsening vision
• I understand I must tell the BLENREP REMS if I change my BLENREP doctor.
• I understand I must tell the BLENREP REMS if my contact information changes.
• I understand GlaxoSmithKline and its agents 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 U.S. Food and Drug Administration (FDA) to evaluate the BLENREP REMS. However, my name will not be shared.
• I give permission for GlaxoSmithKline and its agents to contact me or my prescriber by phone, mail, or email to manage the BLENREP REMS.

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If Patient/Legal Guardian is unable to sign

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OR

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 Delegate by checking the box below indicating the patient has provided verbal attestation.

Date of Verbal Attestation*: ____________________________ Month/Day/Year

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*: ____________________________ Month/Day/Year

Prescriber Acknowledgement
I have reviewed and discussed the risks of BLENREP and the requirements of the BLENREP REMS with this patient.

Prescriber Signature*: ____________________________ Date*: ____________________________ Month/Day/Year