MyMoment Patient Support

Patient Enrolment Form

BLENREP belantamab mafodotin

Please email or fax completed form to your MyMoment Coordinator

Email: support@mymoment.ca	**Fax:** 1-866-751-6368	**Phone:** 1-888-906-6368 **Hours of operation:** Monday to Friday 8 am – 8 pm ET, excluding Ontario statutory holidays

DO NOT SEND PATIENT INFORMATION TO GSK

***Mandatory fields**

PATIENT INFORMATION

***SAP PATIENT:** ☐ Yes ☐ No	***SAP ID #:**
***First name:**	***Last name:**
Date of birth DD/MMM/YYYY:	Language preference: ☐ English ☐ French ☐ Other _____
Address:	
City: / Province: / Postal code:	
Patient gender: ☐ Male ☐ Female ☐ Other _____	
***Phone:**	***Email address:**
***Can we leave a message at this phone number:** ☐ Yes ☐ No	
Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening	

CAREGIVER INFORMATION

First name:	Last name:
Phone:	Email address:

PRESCRIBER INFORMATION

Prescriber name:	
Hospital/Centre name:	
Address:	
City:	Province:
Postal code:	Email address:
Phone:	Fax:
Place of infusion: ☐ Hospital ☐ Private infusion clinic Notes:	
Designee Nurse or Drug Access Navigator name:	
Designee phone:	Designee email:
Preferred method of contact: ☐ Phone ☐ Email	

EYE CARE COORDINATION INFORMATION

☐ ***I request that MyMoment Patient Support Program provide my patient with an eye care professional**

☐ ***I have a preferred eye care professional I will refer my patient to (if checked, please consider completing the information below)**

Preferred eye care professional information ☐ Optometrist ☐ Ophthalmologist

Clinic name:	Eye care professional name:	
Address:		
City:	Province:	Postal code:
Phone:	Email address:	
Preferred method of contact: ☐ Phone ☐ Email		

CLINICAL INFORMATION & PRODUCT REQUIREMENTS

***Indication**
BLENREP (belantamab mafodotin for injection) is indicated in combination with:

☐ bortezomib and dexamethasone, for the treatment of adults with relapsed or refractory multiple myeloma who have received at least one prior line of therapy

☐ pomalidomide and dexamethasone for the treatment of adults with relapsed or refractory multiple myeloma who have received at least one prior line of therapy, including lenalidomide

To meet the eligibility of this program, patients must be prescribed BLENREP in accordance with the Product Monograph approved by Health Canada.

***Line of therapy**
☐ 2nd line treatment ☐ 3rd or later line treatment

***Treatment history**
***Please answer "Yes" or "No" and specify where required for the following:**

Previous anti-BCMA therapy ☐ Yes ☐ No
If yes, please specify: _____
Good performance status: ☐ Yes ☐ No
ECOG: _____
Previous lenalidomide therapy ☐ Yes ☐ No
Previous anti-CD38 therapy ☐ Yes ☐ No
Previous autologous stem cell transplant (ASCT) ☐ Yes ☐ No

*BLENREP STARTING DOSE PRESCRIPTION INFORMATION

☐ BLENREP 2.5 mg/kg (IV) with **V** and **d** (cycle length = 3 weeks)

☐ BLENREP 2.5 mg/kg (IV) with **P** and **d** (cycle length = 4 weeks)

***Therapy start date DD/MMM/YYYY:**	***Patient weight (kg):**

Subsequent dosage of BLENREP should be individualized for each patient. Refer to the Product Monograph for complete information on dosing and administration.

INSURANCE PROVIDER INFORMATION

Insurance provider name: (e.g., Sun Life)

Plan holder name: (e.g., patient, patient's caregiver, patient's spouse/partner)

I authorize the Program Administrator in the context of the Program to be my designated agent to forward the prescription by fax or other mode of delivery to the pharmacy chosen by the above-named patient. This prescription represents the original prescription drug order. By signing, you indicate you have read, understand, and agree to the Prescriber Authorization statement on the other side of the form.

***Prescriber name:**
***Prescriber signature:**
***Date DD/MMM/YYYY:**

License #:

Please make sure the patient signs after reading the Patient Authorization statement on the back of this page.

Patient Authorization

By signing this form (or providing verbal consent) you agree to enroll into the MyMoment Patient Support Program and have read and fully understand the information below:

The MyMoment Patient Support Program ("Program") is designed to facilitate access and provide assistance to qualifying patients that have been prescribed BLENREP. The services under the Program may include: (i) reimbursement investigation and/or financial assistance, (ii) assistance with drug administration or medication dispensing or delivery, (iii) eye care management resources and delivery and (IV) disease and medication resources.

The Program is a GSK Program and administered by a third-party service provider ("Service Provider") selected by GSK. In the event that GSK appoints a new Service Provider, I understand that My Information may be transferred to the new Service Provider in order to ensure the continuity of the Program services. I authorize the Service Provider (Sentrex Health Solutions) on behalf of GSK, to contact as well as to collect further information from me, my caregiver(s), my prescribing practitioner, pharmacist, nurse, and other healthcare professionals involved in my care as well as any insurer, or government agency, as deemed necessary to ensure the accuracy and completeness of this application and to administer the Program.

I acknowledge that the Service Provider, on behalf of GSK, may collect and store (i) personal information such as my name, address, phone number, date of birth; (ii) medical information as it relates to my medical condition for which BLENREP has been prescribed, including patient-reported outcome data and (iii) insurance information such as information related to my health insurance coverage, collectively referred to as "My Information or Your Information." I consent to the collection, use and disclosure of My Information for the services provided under the Program.

GSK does not, in the normal course, access Your Information and relies on the Service Provider to do so when administering the Program; however, GSK may directly access Your Information in limited circumstances, for example, to transfer your personal information to a new Service Provider, to perform audits of the Program in order to evaluate or improve the Program, or for regulatory reporting purposes (e.g., reporting adverse reactions to a government agency).

At times, insurers may require the collection of medical information associated with the administration of BLENREP and such data may be disclosed to insurers and regulatory bodies as required to enable reimbursement. I agree to be contacted by the Service Provider as needed to complete questionnaires or provide feedback on the services I receive pertaining to my medical condition or BLENREP for the purpose of market research and assessing the quality of services provided under the Program.

I acknowledge the Service Provider may provide GSK with anonymized or aggregated information collected during the Program, which may be used by GSK for clinical or health outcomes research, market research or internal evaluation purposes, and disclosed by GSK to third parties in accordance with GSK's Privacy Notice: https://privacy. gsk.com/en-ca/privacy-notice/general.

I understand My Information will be stored in a secure database, with access restricted to authorized personnel. Safeguards are used to protect My Information against unauthorized access, disclosure, copying, use or modification. I have the right to request access to My Information that GSK and/or its third-party service providers have on file, subject to applicable legal restrictions, which includes the right to correct that information and to receive an account of how it has been used and a list of the organizations to whom it has been disclosed. I may request access to, make inquiries of or raise concerns related to the use of My Information by contacting the Service Provider at 1-888-906-6368 or by email at support@mymoment.ca. I understand and accept that My Information may be stored or processed outside of my province/territory or country and that the laws of those regions regarding privacy may be less stringent than the laws of Canada and its provinces. In addition, I understand, accept, and agree that My Information may be used or disclosed to any party to the extent such disclosure is required by applicable law, regulation, or court order.

I understand that (i) I do not have to consent to this Authorization but, if I do not, I will not be able to participate in the Program; (ii) consenting to this Authorization is not a requirement for insurance coverage and will not affect my insurance enrollment; (iii) participation in the Program is not required for me to have access to BLENREP; (iv) acceptance into the Program is based on predefined criteria. If criteria is not met I may be withdrawn or declined from the Program; (v) GSK may cancel or revise the Program at any time; (vi) I may revoke this Authorization at any time by mailing a letter to: Sentrex Health Solutions, 120 Valleywood Drive, Markham, ON L3R 6A7 or such other address as Service Provider may advise, but, if I do so, I will no longer be able to participate in the Program; (vii) revoking the Authorization will prohibit use and disclosures of My Information AFTER the date my letter of revocation is received and processed, but will not affect GSK's ability to use the disclosed information already received, solely for the purposes of the Program.

*PATIENT AUTHORIZATION

☐ **I have read, understand, and agreed to the Patient Authorization statement and agree to the collection, use and disclosure of my personal information and health information in accordance with those terms.**

☐ **I agree to receive emails about upcoming GSK research opportunities.**

Signature of Patient or Legal Representative

Date DD/MMM/YYYY

Name of Patient or Legal Representative

Legal Representative Relationship to Patient

OR

Verbal consent obtained:

☐ **Patient has certified that they have read, understand, and agree to the Patient Authorization statement.†**

☐ **Patient has certified that they agree to receive emails about upcoming GSK research opportunities.**

Signature of person collecting verbal consent

Name of person and title

Date Verbal Consent Collected DD/MMM/YYYY

Prescriber Authorization

Please read the information included in the Patient Authorization section to obtain a full description of the MyMoment Patient Support Program ("Program") and if you agree, sign where indicated.

I certify that this Product has been prescribed for this patient based on my independent medical judgment and the patient's informed consent. I acknowledge that the patient's participation in this Program will be terminated in the event of use that is inconsistent with the Product Monograph.

I agree to be contacted by Sentrex Health Solutions ("Service Provider") and/or GSK about the patient, the Product, or Product complaints. I consent to the use of my prescribing information for the purpose of administering, monitoring, and assessing the Program.

I authorize the Service Provider in the context of the Program to be my designated agent to forward the prescription by fax or other mode of delivery to the pharmacy chosen by the above-named patient.

I understand that my information, including my prescribing information may be shared with GSK for the purpose of assessing the Program.

I acknowledge that adverse events may be reported about my patient participating in the Program and understand that I may be contacted by GSK or its agents and/or the Service Provider to provide follow-up information to Health Canada.

This prescription represents the original prescription drug order.

I agree to keep all confidential information provided to me about the Program in strict confidence and shall not, without prior written consent, disclose any confidential information to any third party.

By submitting this enrolment form you acknowledge and accept the responsibility of overseeing the inclusion and administration of other medicines in the prescribed treatment combination.

Consult the Product Monograph at **gsk.ca/BLENREP/PM** for important information relating to contraindications, warnings, precautions, adverse reactions, interactions, dosing and conditions of clinical use. To request a Product Monograph or report an adverse event, please call 1-800-387-7374.

†A friend or family member cannot collect patient authorization. Only healthcare staff, including doctors, nurses, drug access navigators or Program coordinators, are authorized to collect verbal consent from the patient.

BCMA: B-cell maturation antigen; CD38: Cluster of differentiation 38; ECOG: Eastern cooperative oncology group; IV: Intravenous.

105056 08/25

GSK

MEMBER OF INNOVATIVE MEDICINES CANADA

BLENREP belantamab mafodotin