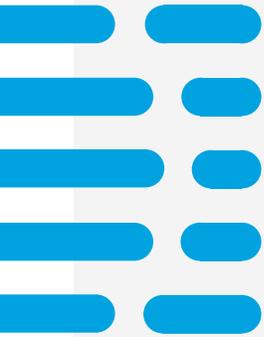




GSK HCP PORTAL USER GUIDE

Specialty (Benlysta)

July 2025



Contents



+ Header/Footer Links.....	2	+ Practice -> Prescribers.....	22
+ Login Page.....	3	+ Practice -> Patients.....	23
+ Register your Practice.....	8	+ Navigation Menu: Claims.....	27
+ Account Activation.....	17	+ Claims -> Submit a Claim.....	27
+ Navigation Menu: Home.....	18	+ Add a Patient (already has a card).....	30
+ Navigation Menu: Contact Us.....	19	+ Enroll a Patient (does not have a card).....	32
+ Navigation Menu: Practice.....	20	+ Claims -> Claims History.....	39
+ Practice -> Account.....	20	+ Paynuver Guide.....	40
+ Practice -> Users.....	21		

Header/Footer Links



HEADER LINKS

Name	URL
Benlysta Logo	https://hcp.benlystacopayprogram.com/Account

Name	URL
Privacy Policy	https://www.iqvia.com/about-us/privacy
Terms of Use	https://www.iqvia.com/about-us/terms-of-use
Contact Us	https://hcp.benlystacopayprogram.com/Home/ContactUs
GSK Copay Terms and Conditions	https://www.gskforyou.com/programs/copay-assistance/
GSK Privacy Statement	https://privacy.gsk.com/en-us/privacy-notice/
GSK Terms of Use	https://us.gsk.com/en-us/legal-notices/

Login Page



Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Welcome to the Benlysta HCP Copay Portal

To submit a medical co-pay claim you will need:

- Explanation of Benefits (EOB) or Claims Remittance Advice (EOA)
- Documentation provided via portal must include:
 - Patient cost share for the GSK drug covered in the program
 - Patient cost share for administration fee related to injection or infusion of the GSK drug covered in the program
 - Named patient who is covered / eligible for the GSK copay program
 - GSK product name or the associated J Codes

If submitting via mail or fax, HCP / Account seeking reimbursement and provider address must also be included.

Sign in

Email

Password [Forgot password?](#)

Remember my email

[Sign in](#) or [register your practice](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement | GSK Terms of Use
©2023 GSK group of companies. All rights reserved.

Error Message

Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Welcome to the Benlysta HCP Copay Portal

To submit a medical co-pay claim you will need:

- Explanation of Benefits (EOB) or Claims Remittance Advice (EOA)
- Documentation provided via portal must include:
 - Patient cost share for the GSK drug covered in the program
 - Patient cost share for administration fee related to injection or infusion of the GSK drug covered in the program
 - Named patient who is covered / eligible for the GSK copay program
 - GSK product name or the associated J Codes

If submitting via mail or fax, HCP / Account seeking reimbursement and provider address must also be included.

Sign in

Email

Password [Forgot password?](#)

Remember my email

[Sign in](#) or [register your practice](#)

Invalid username or password.

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Login Page



Forgot Password? -> Reset Your Password

Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Reset Your Password

Please enter the email address associated with your account. You will receive an email with a link to reset your password.

You will only receive an email if your practice has been approved and your email address has been registered at the practice.

Email Address

I'm not a robot 

[Send Email](#)

Need help?
Call Customer Support
(800) 741-0375
8:00 AM - 8:00 PM ET Mon-Fri

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA 

Reset Your Password: Password Reset Sent

Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Reset Your Password

 **Password Reset Sent**

Click the link in your email to reset your password.
Your link will be valid for 30 minutes

If a valid account was found for your email address, we have sent you a password reset link. Please check your inbox for an email from donotreply@benlystacopayprogram.com.

If you do not see the email, please check your junk mail folder and make sure Jessica.Rubin2@iqvia.com is the correct email address for your Benlysta HCP Copay Portal account. You can also [click here](#) to receive a new link.

Need help?
Call Customer Support
(800) 741-0375
8:00 AM - 8:00 PM ET Mon-Fri

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA 

Login Page



Reset Password: Email triggered using approved template

- Link brings user to this page

Change Your Password

Login Page



Error Message

Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Change Your Password

Old Password

The Old Password field is required.

New Password

The New Password field is required.

Confirm Password

The Confirm Password field is required.

Your password should have:

- at least 8 characters
- at least 1 lowercase letter (a-z)
- at least 1 uppercase letter (A-Z)
- at least 1 number (0-9)
- at least 1 special character, such as ! @ # \$ % ^ & * + =

Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Change Your Password

Old Password

New Password

Confirm Password

Passwords must match.

Your password should have:

- at least 8 characters
- at least 1 lowercase letter (a-z)
- at least 1 uppercase letter (A-Z)
- at least 1 number (0-9)
- at least 1 special character, such as ! @ # \$ % ^ & * + =

Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA



Login Page



Password updated

Benlysta (belimumab) | Home | Claims | Practice | Contact Us | Jessica.Rubin2@iqvia.com

Welcome, Jessica

Your password has been updated.

[Submit a Claim](#)

Need help?
Call Customer Support
(800) 741-0375
8:00 AM – 8:00 PM ET Mon-Fri

Recent Claims [See all claims](#)

Status	Confirmation #	Card ID #	Patient	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
New Claim	134370	T34100100625	NOCARDLN, NOCARDFN	TestLast, TestDoc		7/21/2023		View

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Register Your Practice



Create Practice Account

Introduction

To begin, a representative from the prescribing physician's practice must complete the practice registration process.

Before you may begin using the Benlysta HCP Copay Portal, each user within the practice must activate his or her own account individually.

User activation does not have to be completed at the time of practice registration, but must be completed before you may begin using the Benlysta HCP Copay Portal.

You will need the following information in order to successfully register your practice:

1. User information including email address (you may add additional users at a later date)
2. Practice location information
3. Prescriber licensing information
 - a. Prescriber National Provider Identifier (NPI)
 - b. State License Number (optional)

You will be asked to agree to the Benlysta HCP Copay Portal Agreement. You must agree to these terms to proceed with the Benlysta HCP Copay Portal.

[Begin](#)

[Privacy Policy](#) | [Terms of Use](#) | [Contact Us](#) | [GSK Copay Terms and Conditions](#) | [GSK Privacy Statement](#)

©2023 IQVIA



About The Practice



Create Practice Account

About The Practice

Please enter the information requested below. We will use this information to verify your practice.

Practice Name

Practice NPI Tax ID

Street Address

Address Line 2 (optional)

City

State ZIP

Phone Email Address

Payment Method

You can receive payment for your claims by any of the methods below. Electronic payments require additional setup on our payment provider's website.

Electronic Your electronic payment account is funded.

[Next](#)

[Privacy Policy](#) | [Terms of Use](#) | [Contact Us](#) | [GSK Copay Terms and Conditions](#) | [GSK Privacy Statement](#)

©2023 IQVIA



Register Your Practice



Error Message

Create Practice Account
About The Practice

Please enter the information requested below. We will use this information to verify your practice.

Practice Name

Name is required.

Practice NPI **Tax ID**
NPI is required. Tax ID is required.

Street Address

Street Address is required.

Address Line 2 (optional)

City

City is required.

State **ZIP**
State is required. ZIP is required.

Phone **Email Address**
Phone is required. Email Address is required.

Payment Method

You can receive payment for your claims by any of the methods below. Electronic payments require additional setup on our payment provider's website.

Your electronic payment account is funded.

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

About You

Create Practice Account
About You

Please enter this information about yourself. We will send an account activation email to the email address you specify below. We may use the phone number below to contact you if additional information is required to verify your practice.

Email Address
Your activation email will be sent to this address.

First Name

Last Name

Phone Number **Extension**
(###) ###-####

Role in Practice

Next

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Register Your Practice



Error Message



Create Practice Account

About You

Please enter this information about yourself. We will send an account activation email to the email address you specify below. We may use the phone number below to contact you if additional information is required to verify your practice.

Email Address Your activation email will be sent to this address.

Email is required.

First Name

First Name is required.

Last Name

Last Name is required.

Phone Number **Extension**

Phone is required.

Role in Practice

User Role is required.

[Next](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA



Create Practice Account

Practice Already Registered

A practice with NPI number 5555555555 has already been registered.
Please contact your administrator to get an account, or contact support if you believe you received this message in error.

[Back](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA



Register Your Practice



Create Practice Account Additional Users

Please enter this information about yourself. We will send an account activation email to the email address you specify below. We may use the phone number below to contact you if additional information is required to verify your practice.

Email Address Your activation email will be sent to this address.

This email address is already in use.

First Name

Last Name

Phone Number Extension

Role in Practice

Additional Users

Create Practice Account Additional Users

You can add up to three additional users at this practice, or skip this step and add more users after your account is activated.

Name	Email Address	Role	Admin	Edit
Jessica Rubin	Jessica.Rubin2@iqvia.com	Officer/Billing Administrator	<input type="checkbox"/>	Edit

[Add a User](#)



Register Your Practice



Clicking Add a User brings up this window

Create Practice Account - Additional Users

You can add up to three additional users at this practice.

Name	Email Address	Admin
Jessica Rubin	Jessica.Rubin@iqvia.com	<input type="checkbox"/>

Add a User Next

User

Email Address An activation email will be sent to this address.

First Name

Last Name

Phone Number (###) ###-#### Extension

Role in Practice Administrator Administrators can manage users and prescribers at the practice.

Save Cancel

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Error Message

Create Practice Account - Additional Users

You can add up to three additional users at this practice.

Name	Email Address	Admin
Jessica Rubin	Jessica.Rubin@iqvia.com	<input type="checkbox"/>

Add a User Next

User

Email Address An activation email will be sent to this address.
Email is required.

First Name

Last Name

Phone Number (###) ###-#### Extension

Role in Practice Administrator Administrators can manage users and prescribers at the practice.

Save Cancel

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Create Practice Account - Additional Users

You can add up to three additional users at this practice.

Name	Email Address	Admin
Jessica Rubin	Jessica.Rubin@iqvia.com	<input type="checkbox"/>

Add a User Next

User

Email Address An activation email will be sent to this address.
This email address is already in use.

First Name

Last Name

Phone Number (###) ###-#### Extension

Role in Practice Administrator Administrators can manage users and prescribers at the practice.

Save Cancel

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Register Your Practice



About the Prescriber

Create Practice Account
About the Prescriber

At least one prescriber from your practice must be added in order to verify the practice.

Prescriber First Name

Prescriber Last Name

NPI Number State License Number (optional)

[Next](#)

Additional Prescribers

Create Practice Account
Additional Prescribers

You can add up to three more prescribers now, or skip this step and add prescribers after your account is activated.

Name	NPI	SLN	
TestDoc-TestLast	5555555557	New York	Edit

[Add a Prescriber](#)

[Next](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Error Messages

Create Practice Account
About the Prescriber

At least one prescriber from your practice must be added in order to verify the practice.

Prescriber First Name

First Name is required.

Prescriber Last Name

Last Name is required.

NPI Number State License Number (optional)
NPI Number is required.

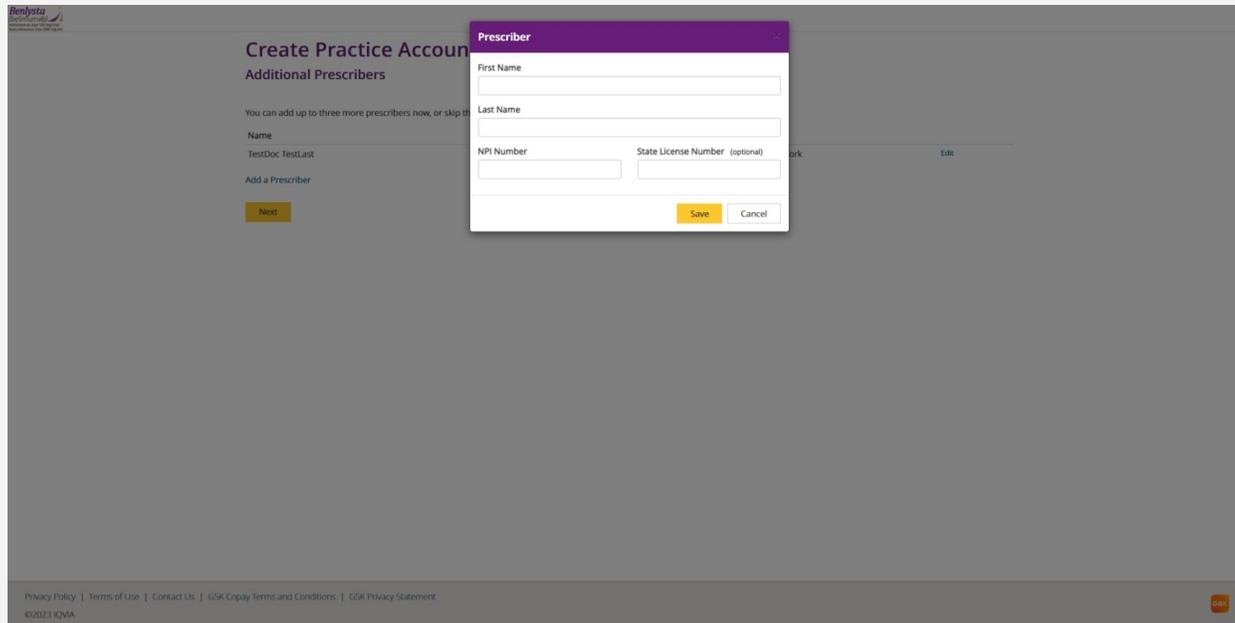
[Next](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

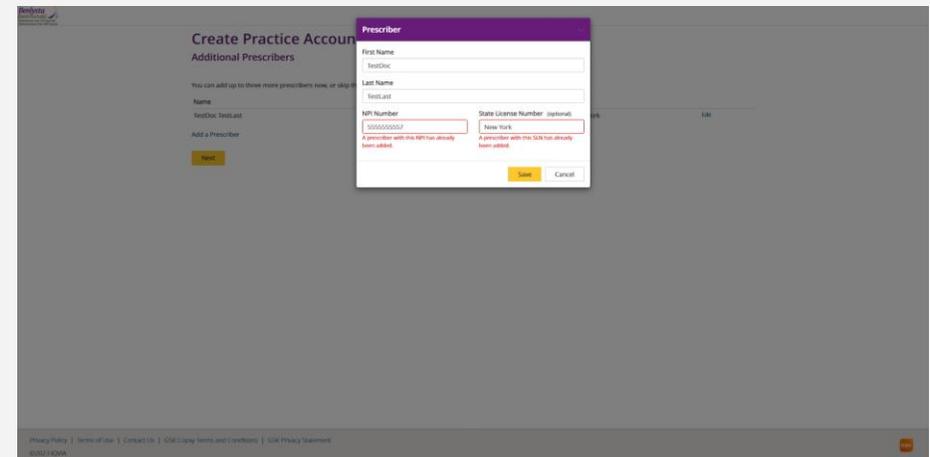
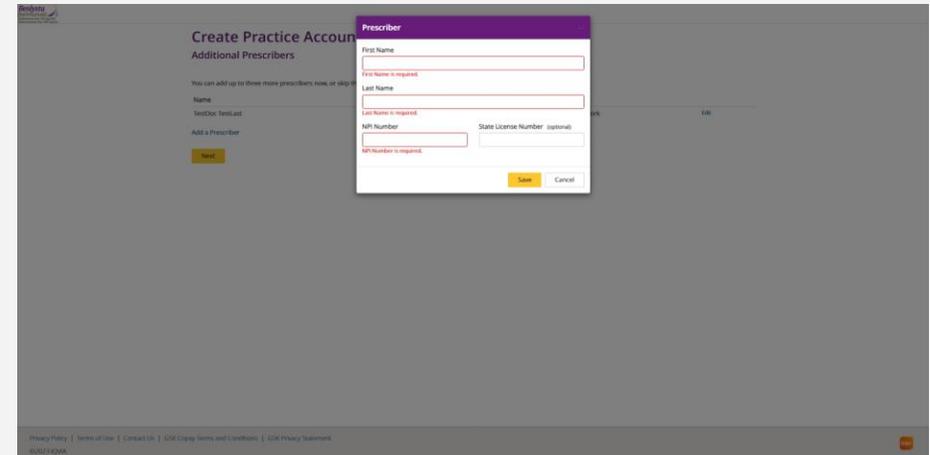
Register Your Practice



Clicking Add a Prescriber brings up this window



Error Messages



Register Your Practice



Review Registration

Create Practice Account
Review Registration

Please review the information below before submitting your registration.

Practice [Edit](#)

TestBenlystaPractice

NPI: 555555555

Tax ID: 44-444444

Phone: (333) 333-3333

Address:
123 Main Street
Any, NJ 12345

Payments will be received by electronic transfer.
* Requires additional setup after registration.

[Next](#)

Users [Edit](#)

Name	Email Address	Role
Jessica Rubin	Jessica.Rubin2@iqvia.com	Officer/Billing Administrator
Jessica Rubin	jrubin@us.imshealth.com	Physician's Assistant

Prescribers [Edit](#)

Name	NPI	SLN
TestDoc TestLast	5555555557	New York
TestDoc TestLast	5555555558	

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Practice Agreement

Create Practice Account
Practice Agreement

Please sign below the following Terms and Conditions to indicate your understanding and acceptance of the terms and conditions of participation of this GSK Copay Program.

I certify that the information provided in claims submitted to IQVIA Inc., Patient Access and Affordability Solutions Division as part of this GSK Copay Program will be accurate; that expenses requested for payments will be eligible patient co-pay, co-insurance, or deductible expenses, actually incurred and not paid by the patient's insurance, Flexible Spending Account, Health Savings Account, or any other payer; and that I would, in the ordinary course of my practice, have charged my patient for such out-of-pocket expenses. I also certify that I will ensure that each patient for whom I submit documentation under this Program (i) will not be purchasing their prescriptions with benefits from Medicare, including Medicare Part D or Medicare Advantage Plans; Medicaid, including Medicaid Managed Care or Alternative Benefit Plans ("ABPs") under the Affordable Care Act; Medicaid; Veterans Administration ("VA"); Department of Defense ("DoD"); TRICARE®; or any similar state-funded programs, such as medical or pharmaceutical assistance programs; and (ii) will meet the other eligibility criteria for the program. Any other expenses, including, but not limited to, out-of-network amounts not covered by patient's insurance, are not eligible for payment under this Program. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

I also understand that IQVIA reserves the right to verify submitted claims information at any time.

Acknowledged and Agreed

Enter your name to accept

TestDoc: TestLast:

I'm not a robot

[Finish](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement | GSK Terms of Use
©2023 GSK group of companies. All rights reserved.

Register Your Practice



Error Message

Create Practice Account
Practice Agreement

Please sign below the following Terms and Conditions to indicate your understanding and acceptance of the terms and conditions of participation of this HCP Medical Co-pay Program.

I certify that the information provided in claims submitted to IQVIA Inc., Patient Access and Affordability Solutions Division as part of this HCP Medical Co-pay Program will be accurate; that expenses requested for payments will be eligible patient co-pay, co-insurance, or deductible expenses, actually incurred and not paid by the patient's insurance, Flexible Spending Account, Health Savings Account, or any other payer; and that I would, in the ordinary course of my practice, have charged my patient for such out-of-pocket expenses. I also certify that I will ensure that each patient for whom I submit documentation under this Program (i) will not be purchasing their prescriptions with benefits from Medicare, including Medicare Part D or Medicare Advantage Plans; Medicaid, including Medicaid Managed Care or Alternative Benefit Plans ("ABPs") under the Affordable Care Act; Medicaid; Veterans Administration ("VA"); Department of Defense ("DoD"); TRICARE®; or any similar state-funded programs, such as medical or pharmaceutical assistance programs; and (ii) will meet the other eligibility criteria for the program. Any other expenses, including, but not limited to, out-of-network amounts not covered by patient's insurance, are not eligible for payment under this Program. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

I also understand that IQVIA reserves the right to verify submitted claims information at any time.

Acknowledged and Agreed

Enter your name to accept

First Name Please enter your first name. Last Name Please enter your last name.

I'm not a robot

[Finish](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Registration Successful

Practice Registration Submitted: Email triggered using approved template

Create Practice Account
Registration Successful

✓ Your registration was successfully submitted.

Thank you for registering your practice for the Benlysta HCP Copay Portal. We are currently processing your request. You and any users added during registration will receive an account notification email within two (2) business days.

Please note, you will not be able to sign in until your practice has been approved and your account is activated.

[Done](#)

Need help?
Call Customer Support
(800) 741-0375
8:00 AM - 8:00 PM ET Mon-Fri

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Account Activation



Activate Account:
Email triggered using approved template

Account Activation: Set Password

Error Message

Account Activated

Navigation Menu (Home)



Portal Home Page (no recent claims)

The screenshot shows the Benlysta portal home page for user Jessica.Rubin2@iqvia.com. The navigation menu includes Home, Claims, Practice, and Contact Us. The main content area features a 'Welcome, Jessica' message, a 'Submit a Claim' button, and a 'Need help?' section with contact information for customer support. Below this is a 'Recent Claims' section with a 'See all claims' link and a table header. The table is currently empty, displaying the message 'You haven't submitted any claims yet.'

Status	Confirmation #	Card ID #	Patient	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
You haven't submitted any claims yet.								

Portal Home Page (with recent claims)

The screenshot shows the Benlysta portal home page for user Jessica.Rubin2@iqvia.com, displaying a recent claim. The layout is identical to the previous screenshot, but the 'Recent Claims' table now contains one entry.

Status	Confirmation #	Card ID #	Patient	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount
New Claim	134370	T34100100625	NOCARDLN, NOCARDFN	TestLast, TestDoc		7/21/2023		View

Navigation Menu (Contact Us)



 **Benlysta**
(belimumab)

Contact Us

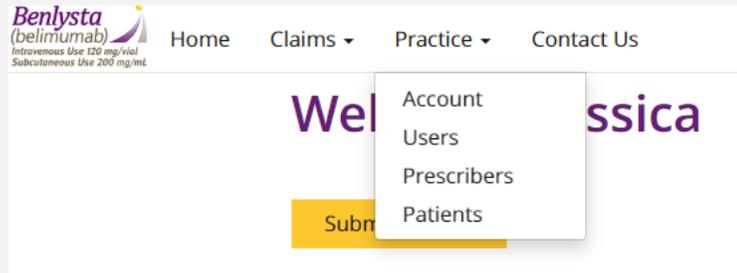
Please feel free to contact us with any questions or issues regarding your account.

Customer Support
(800) 741-0375
8:00 AM – 8:00 PM ET Mon-Fri

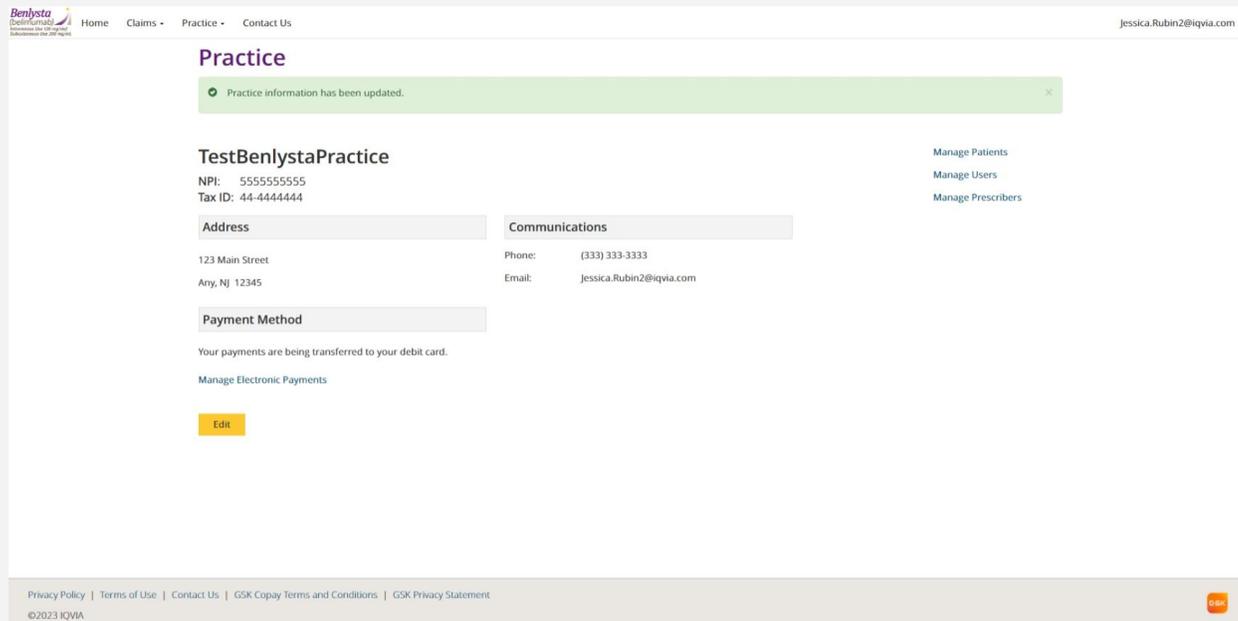
[Privacy Policy](#) | [Terms of Use](#) | [Contact Us](#) | [GSK Copay Terms and Conditions](#) | [GSK Privacy Statement](#)

©2023 IQVIA 

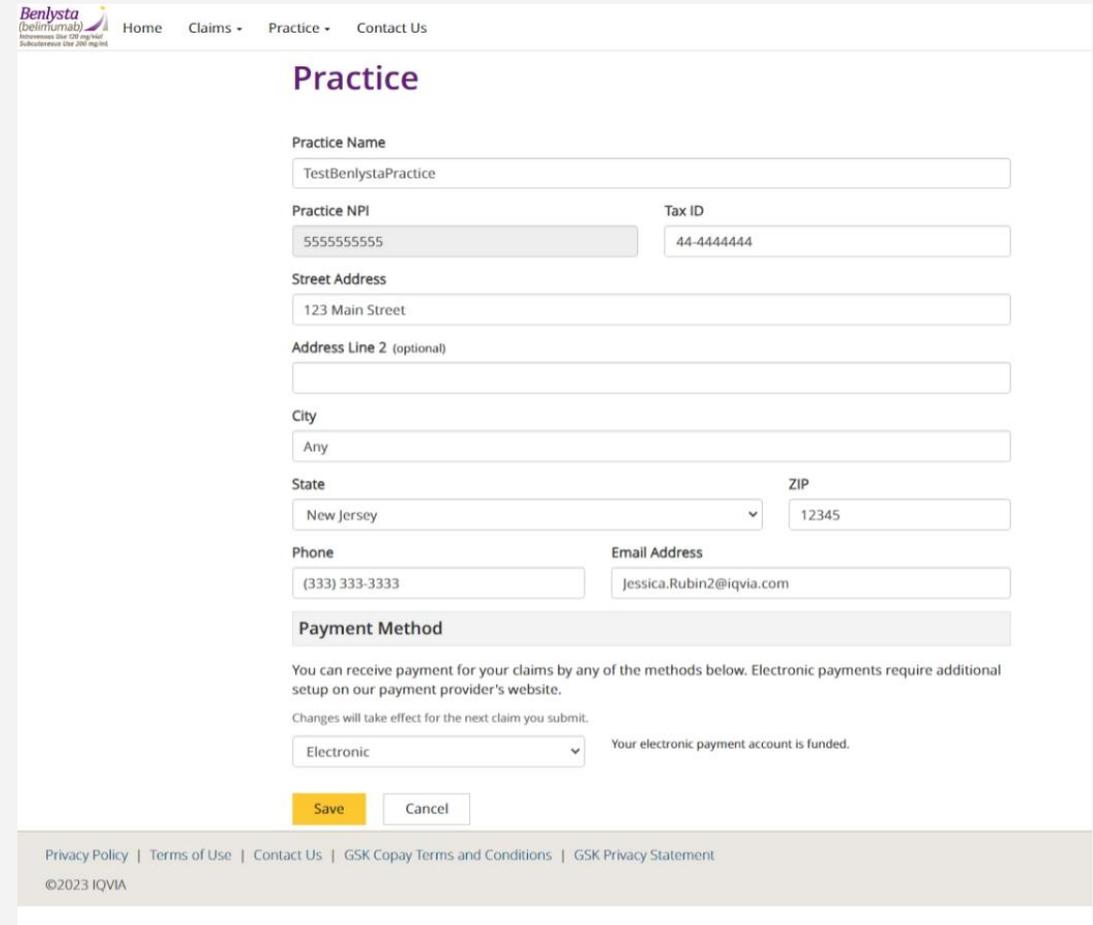
Navigation Menu (Practice -> Account)



Practice -> Account



Edit Practice



Navigation Menu (Practice -> Users)



Practice -> Users

Select Manage Users from Account Page or users from dropdown menu

Name	Email Address	Role	Administrator
Jessica Rubin	Jessica.Rubin2@iqvia.com	Office/Billing Administrator	<input type="checkbox"/> Edit
Jessica Rubin	jrubin@us.imshealth.com	Physician's Assistant	<input type="checkbox"/> Edit

Add a User

User

Email Address (An additional email will be sent to this address.)

First Name

Last Name

Phone Number (Only work email) Extension

Role in Practice Administrator Administrators can manage users and practitioners in the practice.

Save Cancel

Error Message

User

Email Address (An additional email will be sent to this address.)

First Name First Name is required

Last Name Last Name is required

Phone Number (Only work email) Extension

Role in Practice Administrator Administrators can manage users and practitioners in the practice.

User Role is required

Save Cancel

Edit User

User

Email Address (An additional email will be sent to this address.)

First Name

Last Name

Phone Number (310) 333-3333 Extension

Role in Practice Administrator Administrators can manage users and practitioners in the practice.

Save Cancel

Navigation Menu (Practice -> Prescribers)



Practice -> Prescribers

Select Prescribers Users from Account Page or prescribers from dropdown menu

The screenshot shows the Benlysta web application interface. At the top, there is a navigation menu with 'Home', 'Claims', 'Practice', and 'Contact Us'. The user's name 'Jessica.Rubin2@iqvia.com' is displayed in the top right. The main heading is 'Prescribers'. Below it, there is an 'Add a Prescriber' button. A table lists two prescribers:

Name	NPI	SLN	
TestDoc TestLast	555555557	New York	Edit
TestDoc TestLast	555555558		Edit

At the bottom of the page, there is a footer with links for 'Privacy Policy', 'Terms of Use', 'Contact Us', 'GSK Copay Terms and Conditions', and 'GSK Privacy Statement', along with the copyright notice '©2023 IQVIA' and the GSK logo.

Add a Prescriber

This screenshot shows the 'Add a Prescriber' form. A modal dialog titled 'Prescriber' is open, containing input fields for 'First Name', 'Last Name', 'NPI Number', and 'State License Number (optional)'. There are 'Save' and 'Cancel' buttons at the bottom of the modal. The background form is dimmed.

Error Message

This screenshot shows the 'Add a Prescriber' form with an error message. The modal dialog is open, and the 'First Name' field has a red border and the text 'First Name is required' below it. The 'Last Name' field also has a red border and the text 'Last Name is required'. The 'NPI Number' field has a red border and the text 'NPI Number is required'. The 'Save' and 'Cancel' buttons are visible at the bottom of the modal.

Edit Prescriber

This screenshot shows the 'Edit Prescriber' form. A modal dialog titled 'Prescriber' is open, containing input fields for 'First Name', 'Last Name', 'NPI Number', and 'State License Number (optional)'. The 'NPI Number' field is pre-filled with '555555557' and the 'State License Number' is pre-filled with 'New York'. There are 'Save' and 'Cancel' buttons at the bottom of the modal. The background form is dimmed.

Navigation Menu (Practice -> Patients)



Practice -> Patients

Select Manage Patients from Account Page Patients from Prescriber drop down menu

Benlysta (belimumab) Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Patients

Enter the first few letters of the patient's first and/or last name, or leave both fields empty to see all patients.

First Name Last Name

[Add a Patient](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Navigation Menu (Practice -> Patients)



Patient Search Results

- To add a patient, click Add a Patient or go to Submit a Claim

Benlysta
belimumab

Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Patients

Enter the first few letters of the patient's first and/or last name, or leave both fields empty to see all patients.

First Name Last Name

Add a Patient

Name	Date Of Birth	ZIP
------	---------------	-----

No results

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Benlysta
belimumab

Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Submit a Claim

Find a Patient

First Name: Last Name: Q

Name	Date Of Birth	ZIP	View	Submit Claim
BENFN BENLN	01/01/2000	12345	View	Submit Claim
BENFN BENLN	01/01/2000	12345	View	Submit Claim
BENFN BENLN	01/01/2000	12345	View	Submit Claim
NOCARDFN NOCARDLN	01/01/2000	12345	View	Submit Claim
NOCONSENTFN NOCONSENTLN	01/01/2000	12345	View	Submit Claim

Close

Prescriber Declaration: I certify that

- the information provided above is true and accurate and that BENLYSTA is being prescribed for the patient listed above.
- for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out-of-pocket cost for BENLYSTA would be collected from the patient upon treatment.
- the information submitted represents only the eligible patient out of pocket costs associated with BENLYSTA and not patient out of pocket costs for other services provided by me or my office/pharmacy as applicable.

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Navigation Menu (Practice -> Patients)



Patient Record: View

Benlysta | Home | Claims | Practice | Contact Us | Jessica.Rubin2@iqvia.com

Patient

[Submit a Claim](#) [View SmartCard](#)

Name BENFN BENLN	Co-pay Card GRP # QH8910091	Co-pay Card ID # T33100101533
Date of Birth 01/01/2000	Gender Female	
Address 123 MAIN STREET ANY, NJ 12345	Insurance Name Test Payer	
Home Phone (XXX) 333-3333	Insurance BIN 57575757	
Email JESSICA.RUBIN2@IQVIA.COM	Insurance Group PACE	
Electronic Signature ✓ Consent received.	Insurance PCN AJNB	

[Edit](#) [Close](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement | ©2023 IQVIA

Patient Record: Edit

Benlysta | Home | Claims | Practice | Contact Us | Jessica.Rubin2@iqvia.com

Patient

First Name BENFN	Last Name BENLN	Co-pay Card GRP # QH8910091
Date of Birth 01/01/2000	Gender Female	Co-pay Card ID # T33100101533
Street Address 123 MAIN STREET		Insurance Name Test Payer
Address Line 2 (optional)		Insurance BIN 57575757
City ANY		Insurance Group PACE
State New Jersey	ZIP 12345	Insurance PCN AJNB
Phone (XXX) 333-3333	<input checked="" type="radio"/> Home <input type="radio"/> Mobile	
Email JESSICA.RUBIN2@IQVIA.COM		
Electronic Signature ✓ Consent received.		

[Save](#) [Cancel](#)

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement | ©2023 IQVIA

Navigation Menu (Practice -> Patients)



Patient Record: Enrolled by HCP w/o eConsent in place yet

Patient Record: eConsent in place

Clicking View SmartCard brings HCP to Transcard site to access debit details

Patient

● Patient has been added.

No claims can be submitted until patient consent is in place.

Name	Co-pay Card GRP #	Co-pay Card ID #
NOCARDFN NOCARDLN	OH8910101	T34100100625
Date of Birth	Gender	
01/01/2000	Female	
Address	Insurance Name	
123 MAIN STREET ANY, NJ 12345	Test Payer	
Home Phone	Insurance BIN	
(333) 333-3333	22543634	
Email	Insurance Group	
JESSICA.RUBIN2@IQVIA.COM	6757657	
	Insurance PCN	
	76578567	

Electronic Signature

⚠ Awaiting online consent

📧 Resend email

[Edit](#) [Close](#)

Patient

[Submit a Claim](#)

[View SmartCard](#)

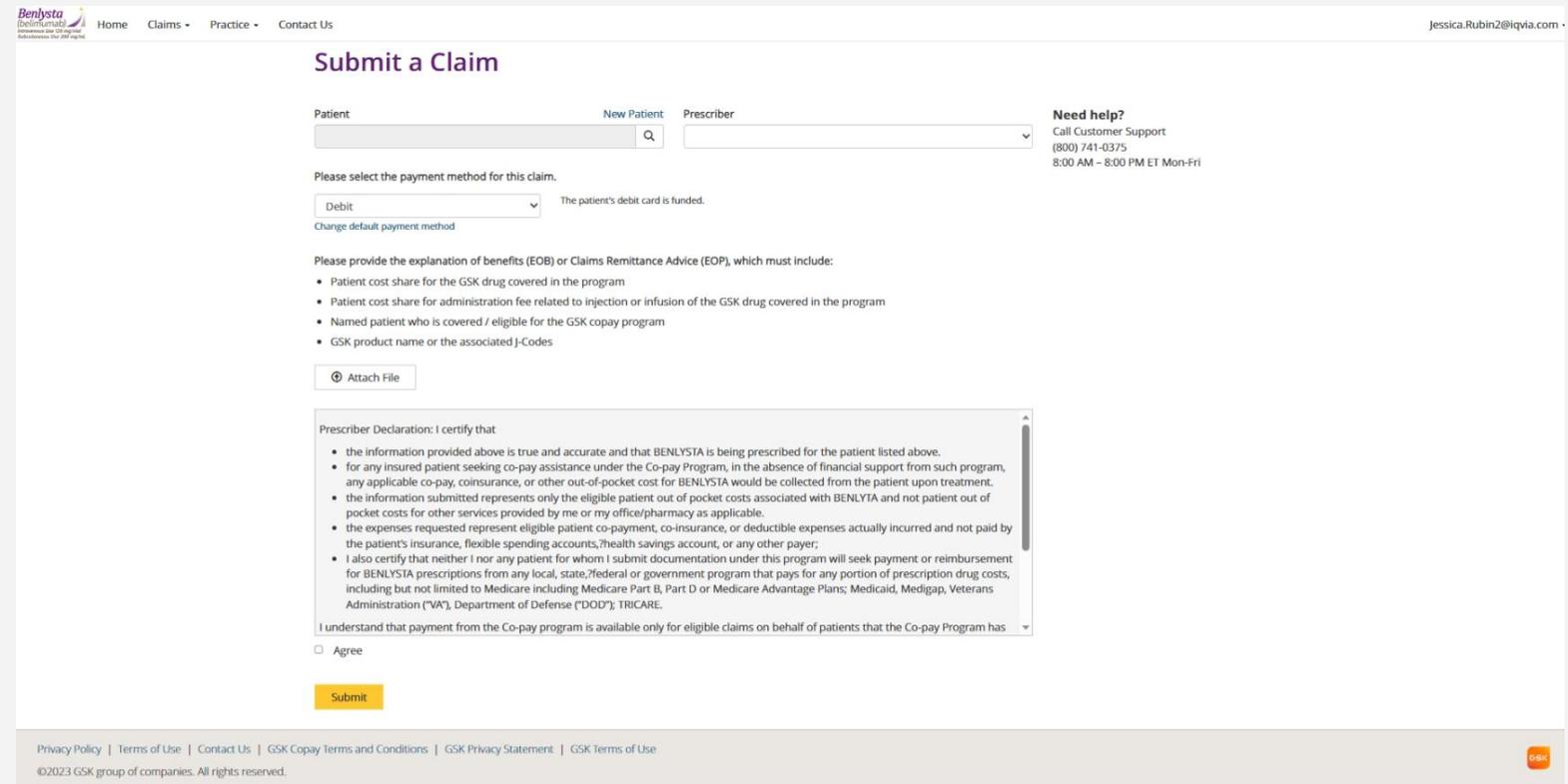
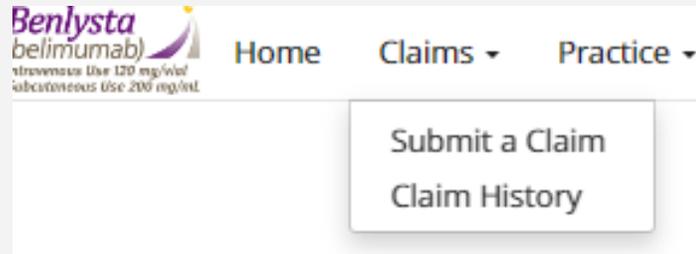
Name	Co-pay Card GRP #	Co-pay Card ID #
NOCARDFN NOCARDLN	OH8910101	T34100100625
Date of Birth	Gender	
01/01/2000	Female	
Address	Insurance Name	
123 MAIN STREET ANY, NJ 12345	Test Payer	
Home Phone	Insurance BIN	
(333) 333-3333	22543634	
Email	Insurance Group	
JESSICA.RUBIN2@IQVIA.COM	6757657	
	Insurance PCN	
	76578567	

Electronic Signature

✔ Consent received.

[Edit](#) [Close](#)

Navigation Menu (Claims)



Claims -> Submit a Claim

Patient and prescriber are prepopulated if selected from patient screen or patient search results

Clicking Change default payment method brings user to Practice Edit page

Navigation Menu (Claims -> Submit a Claim)



Click on search icon to find patient

Submit a Claim

Patient New Patient Prescriber

Please select the payment method for this claim.
Debit The patient's debit card is funded.

Please provide the explanation of benefits (EOB) or Claims Remittance Advice (EOA), which must include:

- Patient cost share for the GSK drug covered in the program
- Patient cost share for administration fee related to injection or infusion of the GSK drug covered in the program
- Named patient who is covered / eligible for the GSK copay program
- GSK product name or the associated J-Code

I understand that payment from the Co-pay program is available only for eligible claims on behalf of patients that the Co-pay Program has determined to be eligible for the Co-pay program. Other expenses, including, but not limited to, out-of-network amounts not covered by patient's insurance, are not eligible for payment under the Co-pay Program. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

Agree

Find a Patient

First Name: Last Name:

Submit a Claim

Patient NOCARDIN NOCARDIN

Please select the payment method for this claim.
Debit The patient's debit card is funded.

Please provide the explanation of benefits (EOB) or Claims Remittance Advice (EOA), which must include:

- Patient cost share for the GSK drug covered in the program
- Patient cost share for administration fee related to injection or infusion of the GSK drug covered in the program
- Named patient who is covered / eligible for the GSK copay program
- GSK product name or the associated J-Code

Prescriber Declaration: I certify that

- the information provided above is true and accurate and that BENLYSTA is being prescribed for the patient listed above.
- for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, insurance, or other out-of-pocket cost for BENLYSTA would be collected from the patient upon treatment.
- the information submitted represents only the eligible patient out-of-pocket costs associated with BENLYSTA and not patient out-of-pocket costs for other services provided by me or my office/pharmacy as applicable.
- the expenses requested represent eligible patient co-payment, co-insurance, or deductible expenses actually incurred and not paid by the patient's insurance, flexible spending accounts, health savings accounts, or any other payer.
- I also certify that neither I nor any patient for whom I submit documentation under this program will seek payment or reimbursement for BENLYSTA prescriptions from any local, state, federal or government program that pays for any portion of prescription drug costs, including but not limited to Medicare including Medicare Part B, Part D or Medicare Advantage Plans; Medicaid; Medigap; Veterans Administration (VA), Department of Defense (DOD), TRICARE.

I understand that payment from the Co-pay program is available only for eligible claims on behalf of patients that the Co-pay Program has determined to be eligible for the Co-pay program. Other expenses, including, but not limited to, out-of-network amounts not covered by patient's insurance, are not eligible for payment under the Co-pay Program. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

Agree

Navigation Menu (Claims -> Submit a Claim)



Find a Patient: Results

Find a Patient

First Name: Last Name:

Name	Date Of Birth	ZIP	View	Submit Claim
BENFN BENLN	01/01/2000	12345	View	Submit Claim
BENFN BENLN	01/01/2000	12345	View	Submit Claim
BENFN BENLN	01/01/2000	12345	View	Submit Claim
NOCARDFN NOCARDLN	01/01/2000	12345	View	Submit Claim

Close

Error Messages

Submit a Claim

Patient: NOCARDFN NOCARDLN New Patient: Prescriber: **Prescriber is required.**

Need help?
Call Customer Support
(800) 741-0375
8:00 AM - 8:00 PM ET Mon-Fri

Please select the payment method for this claim.
Debit The patient's debit card is funded.
Change default payment method

Please provide the explanation of benefits (EOB) or Claims Remittance Advice (ERA), which must include:

- Patient cost share for the GSK drug covered in the program
- Patient cost share for administration fee related to injection or infusion of the GSK drug covered in the program
- Named patient who is covered / eligible for the GSK copay program
- GSK product name or the associated J Codes

Please select a file.

Prescriber Declaration: I certify that

- the information provided above is true and accurate and that BENLYSTA is being prescribed for the patient listed above.
- for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out-of-pocket cost for BENLYSTA would be collected from the patient upon treatment.
- the information submitted represents only the eligible patient out-of-pocket costs associated with BENLYSTA and not patient out-of-pocket costs for other services provided by me or my office/pharmacy as applicable.
- the expenses requested represent eligible patient co-payment, co-insurance, or deductible expenses actually incurred and not paid by the patient's insurance, flexible spending accounts, health savings account, or any other payer.
- I also certify that neither I nor any patient for whom I submit documentation under this program will seek payment or reimbursement for BENLYSTA prescriptions from any local, state, federal or government program that pays for any portion of prescription drug costs, including but not limited to Medicare including Medicare Part B, Part D or Medicare Advantage Plans, Medicaid, Medigap, Veterans Administration (VA), Department of Defense (DOD), TRICARE.
- I understand that payment from the Co-pay program is available only for eligible claims on behalf of patients that the Co-pay

Agree **Agreement is required.**

Navigation Menu (Claims)



Add a Patient (already has a card)

Patient

First Name:

Last Name:

Date of Birth:

Gender:

Street Address:

Address Line 2 (optional):

City:

State:

ZIP:

Phone: Home Mobile

Email:

Does the patient have a card?
 Yes No

Co-pay Card GRP #:

Co-pay Card ID #:

Insurance Name:

Insurance BIN:

Insurance Group:

Insurance PCN:

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Error Messages

Patient

First Name: First Name is required.

Last Name: Last Name is required.

Date of Birth: Date of Birth is required.

Gender: Gender is required.

Street Address: Street Address is required.

Address Line 2 (optional):

City: City is required.

State: State is required.

ZIP: ZIP is required.

Phone: Home Mobile Phone is required.

Email: Email is required.

Does the patient have a card?
 Yes No

Co-pay Card GRP #: Co-pay Card GRP # is required.

Co-pay Card ID #: Co-pay Card ID # is required.

Insurance Name: Insurance Name is required.

Insurance BIN: Insurance BIN is required.

Insurance Group: Required without PCN

Insurance PCN: Required without Group

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Navigation Menu (Claims)



Patient Added to Practice

The screenshot shows a web interface for Benlysta (belimumab) with a navigation menu (Home, Claims, Practice, Contact Us) and a user profile (Jessica.Rubin2@iqvia.com). The main content area is titled 'Patient' and features a green notification bar stating 'Patient has been added.' Below this is a yellow 'Submit a Claim' button and a 'View SmartCard' link. The patient information is organized into two columns:

Field	Value
Name	BENFN BENLN
Date of Birth	01/01/2000
Address	123 MAIN STREET ANY, NJ 12345
Home Phone	(333) 333-3333
Email	JESSICA.RUBIN2@IQVIA.COM
Electronic Signature	✓ Consent received.
Co-pay Card GRP #	OH8910091
Co-pay Card ID #	T33100101533
Gender	Female
Insurance Name	Test Payer
Insurance BIN	57575757
Insurance Group	PACE
Insurance PCN	AJNB

At the bottom of the form are 'Edit' and 'Close' buttons. The footer contains links for Privacy Policy, Terms of Use, Contact Us, GSK Copay Terms and Conditions, and GSK Privacy Statement, along with the copyright notice ©2023 IQVIA and the GSK logo.

Navigation Menu (Claims)



Enroll a Patient (does not have a card)

Benlysta Home Claims Practice Contact Us Benlysta@iqvia.com

Patient

Does the patient have a copy card?
 Yes No

Group: CH8510101

Member ID: #####

Select an Insurance Type
 Prescription Medical

Medical Insurance Name: Aetna

Medical Insurance ID #: W123456789

Welcome Contact Preference: SMS

First Name: [Text] Last Name: [Text]

Date of Birth: [MM/DD/YYYY] Gender: [Male]

Street Address: 123 MAIN STREET

Address Line 2 (optional): [Text]

City: [Text]

State: [New Jersey] ZIP: 08007

Phone: (908) 432-5337 Home Mobile

Email: PSS_Business_Analyst@iqvia.com

Please indicate your preferred method for receiving your eConsent and Smartcard Welcome communication, which will include copay details: If you select SMS, you will be asked to consent to receive text messages. Message and data rates may apply.

I confirm that the patient provided explicit consent to receive their eConsent message and relevant GSK communications via SMS to the mobile number they provided.

Electronic Signature
 The patient will receive a communication via preferred method requesting electronic signature.

Preferred Language (if other than English)

I certify that the information provided above is true and that BENLYSTA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for BENLYSTA would be collected from the patient upon treatment. I appoint the BENLYSTA Gateway, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the BENLYSTA Copay Program.
 Is your patient enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?
 Yes No

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD) programs or TRICARE. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they seek to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Is your patient a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?
 Yes No

Does the Patient have commercial insurance?
 Yes No

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement | GSK Terms of Use
 ©2023 GSK group of companies. All rights reserved.

Phone: (908) 432-5337 Home Mobile

Email: PSS_Business_Analyst@iqvia.com

Please indicate your preferred method for receiving your eConsent and Smartcard Welcome communication, which will include copay details: If you select SMS, you will be asked to consent to receive text messages. Message and data rates may apply.

I confirm that the patient provided explicit consent to receive their eConsent message and relevant GSK communications via SMS to the mobile number they provided.

Electronic Signature
 The patient will receive a communication via preferred method requesting electronic signature.

Welcome Contact Preference: SMS

Error Messages

Benlysta Home Claims Practice Contact Us Benlysta@iqvia.com

Patient

Does the patient have a copy card?
 Yes No

Group: CH8510101

Member ID: #####

Select an Insurance Type
 Prescription Medical

Insurance Name: [Text] **Insurance Name is required.**

Insurance BIN: [Text] **Insurance BIN is required.**

Insurance Group: [Text] **Insurance Group is required.**

Required without PCN: [Text] **Required without PCN.**

Insurance PCN: [Text] **Required without Group.**

Welcome Contact Preference: [Text] **Welcome Contact Preference is required.**

First Name: [Text] Last Name: [Text] **First Name is required.** **Last Name is required.**

Date of Birth: [MM/DD/YYYY] Gender: [Text] **Date of Birth is required.** **Gender is required.**

Street Address: [Text] **Street Address is required.**

Address Line 2 (optional): [Text]

City: [Text] **City is required.**

State: [Text] ZIP: [Text] **State is required.** **ZIP is required.**

Phone: [Text] **Phone is required.** Home Mobile

Email: [Text] **Email is required.**

Electronic Signature
 The patient will receive a communication via preferred method requesting electronic signature.

Preferred Language (if other than English)

I certify that the information provided above is true and that BENLYSTA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking copay assistance under the Copay Program, in the absence of financial support from such program, any applicable copay, coinsurance, or other out-of-pocket cost for BENLYSTA would be collected from the patient upon treatment. I appoint the BENLYSTA Gateway, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy. **Please provide authorization to proceed.**

Please answer the questions below to see if your patient may qualify for the BENLYSTA Copay Program.
 Is your patient enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?
 Yes No **Please make a selection**

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD) programs or TRICARE. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they seek to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Is your patient a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?
 Yes No **Please make a selection**

Does the Patient have commercial insurance?
 Yes No **Please make a selection**

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement | GSK Terms of Use
 ©2023 GSK group of companies. All rights reserved.

Navigation Menu (Claims)



Benlysta Home Claims Practice Contact Us jessica.rubin2@iqvia.com

Patient

First Name Last Name

First Name is required. Last Name is required.

Date of Birth Gender

MM/DD/YYYY Date of Birth is required. Gender is required.

Street Address

Street Address is required.

Address Line 2 (optional)

City

City is required.

State ZIP

State is required. ZIP is required.

Phone Home Mobile

(###) ###-#### Phone is required.

Email

Email is required.

Electronic Signature

The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)

Indication

Please make a selection.

I certify that the information provided above is true and that BENLYSTA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out of pocket cost for BENLYSTA would be collected from the patient upon treatment. I appoint the BENLYSTA Gateway, on my behalf, to convey this prescription to the dispensing pharmacy to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the BENLYSTA Co-pay Program.

Is your patient enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?

Yes No **Your patient is not eligible for the BENLYSTA Co-Pay Program at this time. Please contact Gateway to BENLYSTA for more information at 1-877-4-BENLYSTA (1-877-433-6567).**

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs or Tricare. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they elect to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Is your patient a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?

Yes No **Your patient is not eligible for the BENLYSTA Co-Pay Program at this time. Please contact Gateway to BENLYSTA for more information at 1-877-4-BENLYSTA (1-877-433-6567).**

Does the Patient have commercial insurance?

Yes No **Your patient is not eligible for the BENLYSTA Co-Pay Program at this time. Please contact Gateway to BENLYSTA for more information at 1-877-4-BENLYSTA (1-877-433-6567).**

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement | GSK Terms of Use

©2023 GSK group of companies. All rights reserved.

Benlysta Home Claims Practice Contact Us jessica.rubin2@iqvia.com

Patient

First Name Last Name

BenFN BenLN

Date of Birth Gender

01/01/2000 Female

Street Address

123 Main Street

Address Line 2 (optional)

City

Any

State ZIP

New Jersey 12345

Phone Home Mobile

(333) 333-3333

Email

jessica.rubin2@iqvia.com

Electronic Signature

The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)

Indication

Lupus

I agree to the BENLYSTA Copay Terms & Conditions

I certify that the information provided above is true and that BENLYSTA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out of pocket cost for BENLYSTA would be collected from the patient upon treatment. I appoint the BENLYSTA Gateway, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the BENLYSTA Co-pay Program.

Is your patient enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?

Yes No

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs or Tricare. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they elect to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Is your patient a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?

Yes No

Does the Patient have commercial insurance?

Yes No

This patient is already registered at your practice.

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement

©2023 IQVIA

Navigation Menu (Claims)



Benlysta (belimumab) Home Claims Practice Contact Us anandappa.kuruba1@iqvia.com

Patient

First Name: Anandappa Last Name: Kuruba

Date of Birth: 01/01/2000 Gender: Male

Street Address: Test Address

Address Line 2 (optional): Test Address 1

City: Test City

State: New Jersey ZIP: 99999

Phone: (999) 999-9999 * Home * Mobile

Email: anandappa.kuruba1@iqvia.com

Electronic Signature: The patient will receive an email requesting electronic signature.

Preferred Language (if other than English): Telugu

Indication: Lupus

I agree to the BENLYSTA Copay Terms & Conditions

I certify that the information provided above is true and that BENLYSTA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out-of-pocket cost for BENLYSTA would be collected from the patient upon treatment. I support the BENLYSTA Gateway, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please answer the questions below to see if your patient may qualify for the BENLYSTA Co-pay Program.

Is your patient enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?
 Yes No

Patients are not eligible for this program if they are covered by any federal or state prescription insurance program. This includes patients enrolled in Medicare Part B, Medicare Part D, Medicaid, Medicaid, Veterans Affairs (VA), Department of Defense (DOD) programs or TRICARE. This may also include state pharmaceutical assistance programs and other federal or state plans not listed. Patients are also ineligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government subsidized prescription drug benefit program for retirees. Patients enrolled in a state or federally funded prescription insurance program may not use this program even if they elect to be processed as an uninsured (cash paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity of HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Is your patient a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?
 Yes No

Does the Patient have commercial insurance?
 Yes No

Patient already exists. Please contact support at 800-741-0375 to obtain the patient card details.

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement ©2023 IQVIA

Benlysta (belimumab) Home Claims Practice Contact Us jessica.Rubin2@iqvia.com

Patient

First Name: BenFN Last Name: BenLN

Date of Birth: 01/01/2000 Gender: Female

Street Address: 123 Main Street

Address Line 2 (optional):

City: Any

State: New Jersey ZIP: 12345

Phone: (333) 333-3333 * Home * Mobile

Email: jessica.Rubin2@iqvia.com

Does the patient have a card?
 Yes No

Co-pay Card GRP #: CH8910101

Co-pay Card ID #: 5456545456

Co-pay Card ID # in result:

Insurance Name: Test Fiqer

Insurance BIN: 4564564

Insurance Group: 4566

Insurance PCN: 456454

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement ©2023 IQVIA

Navigation Menu (Claims)



Government Insurance Detected

Same message displays whether patient does or does not already have a card

The screenshot shows a patient profile form with a yellow warning banner at the top: "This patient is not eligible due to government insurance." The form fields include:

- First Name: BenLN
- Last Name: BenLN
- Date of Birth: 01/01/2000
- Gender: Female
- Street Address: 123 Main Street
- Address Line 2 (optional):
- City: Any
- State: New Jersey
- ZIP: 12345
- Phone: (333) 333-3333
- Email: jessica.rubin2@iqvia.com
- Does the patient have a card?: Yes No
- Co-pay Card GRP #: OH8910091
- Co-pay Card ID #: T33100101533
- Insurance Name: Test Payer
- Insurance BIN: 008589
- Insurance Group: PACE
- Insurance PCN: AJNB

Buttons: Save, Cancel

Footer: Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement ©2023 IQVIA

Enrollment Complete: eConsent Email Triggered to Patient using approved template

Patient Profile: Awaiting eConsent

The screenshot shows the patient profile form with a green success banner: "Patient has been added." and a yellow warning banner: "No claims can be submitted until patient consent is in place." The form fields are populated with the same data as the previous screenshot. At the bottom, there are buttons for "Edit" and "Close".

Electronic Signature options:
 Awaiting online consent
 Resend email

Footer: Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement ©2023 IQVIA

Navigation Menu (Claims)



Click Resend email

uat.opushealth.com says

Are you sure you'd like to resend the consent email to JESSICA.RUBIN2@IQVIA.COM?

Patient Profile: Awaiting Online Consent -> Resend email

Benlysta | Home | Claims | Practice | Contact Us | Jessica.Rubin2@iqvia.com

Patient

✔ Patient has been added.

No claims can be submitted until patient consent is in place.

Name	NOCONSENTFN NOCONSENTLN	Co-pay Card GRP #	OH8910101	Co-pay Card ID #	T34100100691
Date of Birth	01/01/2000	Gender	Female		
Address	123 MAIN STREET ANY, NJ 12345	Insurance Name	Test Payer		
Home Phone	(333) 333-3333	Insurance BIN	12342343		
Email	JESSICA.RUBIN2@IQVIA.COM	Insurance Group	563546546		
		Insurance PCN	757467564		

Electronic Signature
⚠ Awaiting online consent
🔄 Resend email
Sent to JESSICA.RUBIN2@IQVIA.COM

Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement
©2023 IQVIA

Navigation Menu (Claims)



Submit Claim enabled once eConsent in place

Benlysta Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Patients

Enter the first few letters of the patient's first and/or last name, or leave both fields empty to see all patients.

First Name Last Name

Add a Patient

Name	Date of Birth	ZIP	
BENFN BENFN	01/01/2000	12345	View Submit Claim
BENFN BENFN	01/01/2000	12345	View Submit Claim
BENFN BENFN	01/01/2000	12345	View Submit Claim
NOCARDFN NOCARDLN	01/01/2000	12345	View Submit Claim
NOCONGENTFN NOCONGENTLN	01/01/2000	12345	View Submit Claim

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement ©2023 IQVIA

Submit a Claim (file attached and agree)

Benlysta Home Claims Practice Contact Us Jessica.Rubin2@iqvia.com

Submit a Claim

Patient: NOCARDFN NOCARDLN Prescriber: TestDoc, TestLast

Please select the payment method for this claim.

Debit The patient's debit card is handy.

Change default payment method

Please provide the explanation of benefits (EOB) or Claims Remittance Advice (ERA), which must include:

- Patient cost share for the GSK drug covered in the program
- Patient cost share for administration fee related to injection or infusion of the GSK drug covered in the program
- Named patient who is covered / eligible for the GSK copay program
- GSK product name or the associated J Codes

Attach File: Test Claim.pdf

Prescriber Declaration: I certify that:

- the information provided above is true and accurate and that BENLYSTA is being prescribed for the patient listed above.
- for any insured patient seeking co-pay assistance under the Co-pay Program in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out-of-pocket cost for BENLYSTA would be collected from the patient upon treatment.
- the information submitted represents only the eligible patient out-of-pocket costs associated with BENLYSTA and not patient out-of-pocket costs for other services provided by me or my office/pharmacy as applicable.
- the expenses requested represent eligible patient co-payment, co-insurance, or deductible expenses actually incurred and not paid by the patient's insurance, flexible spending accounts, health savings account, or any other payer.
- I also certify that neither I nor any patient for whom I submit documentation under this program will seek payment or reimbursement for BENLYSTA prescriptions from any local, state, federal or government program that pays for any portion of prescription drug costs, including but not limited to Medicare including Medicare Part B, Part D or Medicare Advantage Plans; Medicaid; Medicaid; Veterans Administration (VA); Department of Defense (DOD); TRICARE.

I understand that payment from the Co-pay program is available only for eligible claims on behalf of patients that the Co-pay Program is not administered to for individuals that they are not insured. Please ensure that all patients that are not insured.

Agree

Submit

Privacy Policy | Terms of Use | Contact Us | GSK Copy Terms and Conditions | GSK Privacy Statement ©2023 IQVIA

Navigation Menu (Claims)



Claim Submitted

The screenshot displays a web page with a navigation menu at the top containing 'Home', 'Claims', 'Practice', and 'Contact Us'. The user's email 'Jessica.Rubin2@iqvia.com' is visible in the top right corner. The main content area features a purple heading 'Claim Submitted' and a green checkmark icon followed by the text 'The claim has been successfully submitted.' Below this, it states 'The confirmation number is 134370.' and 'You will be notified once the claim is approved.' A link for 'Back to home page' is provided. The footer includes links for 'Privacy Policy', 'Terms of Use', 'Contact Us', 'GSK Copy Terms and Conditions', and 'GSK Privacy Statement', along with the copyright notice '©2023 IQVIA' and a small GSK logo.

Navigation Menu (Starting and Remaining Balance)



Practice → Patient → Starting and Remaining Balance



Benlysta (belimumab) Home Claims Practice Contact Us

Patient

Copay Fund Balance:
\$9,450.00 of \$9,450.00
PLEASE NOTE: The starting and remaining balances are subject to change according to the program terms and conditions.

[Submit a Claim](#)

[Click here to access your patient's virtual copay card](#)

Name	Group	Member ID
[REDACTED]	[REDACTED]	[REDACTED]
Date of Birth	Gender	
[REDACTED]	Female	
Address	Insurance Type	
[REDACTED]	<input checked="" type="radio"/> Prescription <input type="radio"/> Medical	
Email	Insurance Name	
[REDACTED]	Test Payer	
	Insurance BIN	
	2	
	Insurance Group	
	456	
	Insurance PCN	
	77	

[Edit](#) [Close](#)

Status	Confirmation #	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount	
New Claim	137269	Doc.N, DocFN		2/28/2024			View

Navigating to the Paynover Microsite from the HCP Buy and Bill Portal

Welcome, Anandappa

Submit a Claim

Need help?

Call Customer Support
Phone: (800) 741-0375
Fax: (866) 728-8222
8:00 AM – 8:00 PM ET Mon-Fri

Recent Claims [See all claims](#)

Status	Confirmation #	Member ID	Patient	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount	
Payment Authorized	137899	T34100110283	ANANDAPPA, FBBCLAIMRAJA	Kuruba, Anandappa	4/30/2024	4/30/2024	4/30/2024	\$102.02	View
New Claim	137285	T34100105450	KURUBA, ACTIVEACOUN	Kuruba, Anandappa	3/1/2024	3/1/2024	3/1/2024		View
Rejected	135734	09692094133	STEPHENS, ASHLI	Kuruba, Anandappa	10/12/2023	10/12/2023	10/12/2023		View
Payment Authorized	135744	T36100102304	CLAIMPROCESS, JIGNATEST		10/12/2023	10/12/2023	10/12/2023	\$111.15	View
Rejected	135014	T34100102307	RAM, JANA	Kuruba, Anandappa	8/31/2023	8/31/2023	8/31/2023		View

- After logging in to your account, select the Practice Drop down from the top menu bar.

Navigating to the Paynover Microsite from the HCP Buy and Bill Portal

Benlysta (belimumab) intravenous (IV) injection, 200 mg/100 mL solution, 200 mg/100 mL solution, 200 mg/100 mL solution

Home Claims Practice Contact Us

Account
Users
Prescribers
Patients

Welcome, Anandappa

Submit a Claim

Need help?
Call Customer Support
Phone: (800) 741-0375
Fax: (866) 728-8222
8:00 AM – 8:00 PM ET Mon-Fri

Recent Claims [See all claims](#)

Status	Confirmation #	Member ID	Patient	Prescriber	Date of Service	Date Submitted	Date Updated	Claim Amount	
Payment Authorized	137899	T34100110283	ANANDAPPA, FBBCLAIMRAJA	Kuruba, Anandappa	4/30/2024	4/30/2024	4/30/2024	\$102.02	View
New Claim	137285	T34100105450	KURUBA, ACTIVEACCOUN	Kuruba, Anandappa	3/1/2024	3/1/2024	3/1/2024		View
Rejected	135734	09692094133	STEPHENS, ASHLI	Kuruba, Anandappa	10/12/2023	10/12/2023	10/12/2023		View
Payment Authorized	135744	T36100102304	CLAIMPROCESS, JIGNATEST		10/12/2023	10/12/2023	10/12/2023	\$111.15	View
Rejected	135014	T34100102307	RAM, JANAKI	Kuruba, Anandappa	8/31/2023	8/31/2023	8/31/2023		View

- Next, select the “Account” option from the drop down menu

Navigating to the Paynover Microsite from the HCP Buy and Bill Portal



Practice

Anandappa Kuruba

NPI: 1073608998

Tax ID: 11-2223333

Address

Test Address

Test Address 1

Test City, NJ 99999

Communications

Phone: (999) 999-9999

Email: ANANDAPPA.KURUBA@IQVIA.COM

Payment Method

Payments are being electronically transferred to your payment account.

[Manage Electronic Payments](#)

[Edit](#)

[Manage Patients](#)

[Manage Users](#)

[Manage Prescribers](#)

- From this screen, please select the **Manage Electronic Payments** option located near the bottom left of the screen just above **Edit**

Paynover Enhancement -Process Update: Inclusion of Member ID for Transaction Details

TO THE ORDER OF:

Dave Test Practice 1

DATE:

January 15, 2025



Transaction Details: 1/1/2025 - 1/13/2025

Name Registered	Member ID	Prescription Number (RX#)	IQVIA Claim ID	Date Created	Prescription Fill Date	Claim Amount	Disbursement Type

For questions, call Customer Support (800) 555-4820

- Updated Process: First & Last Name | Member ID | RX# | Claim ID | Date Created | Prescription Fill Date | Claim Amount | Disbursement Type
- Previous Process: Claim# | Rx# | Fill Date | Patient First & Last Name

Paynuver Microsite Functionality

Available Balance
\$0.00

[Update Transfer Options](#)
[Account Holder Details](#)
[Return to Payment Account](#)

Accounts

BW Test *6789

+ Create Account

Transaction History

Name	Amount	Created	Balance
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:36 PM	\$0.00
Payment for Claim# 1234898[Rx# 0787899981998 Fill Date 20240227]	\$1.03	02/27/2024 05:36 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:05 PM	\$0.00
Payment for Claim# 1234897[Rx# 0787899981997 Fill Date 20240227]	\$1.03	02/27/2024 05:05 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$0.00
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$1.02
Automatic Disbursement from PA to ACH Transfer	(\$1.01)	02/27/2024 05:04 PM	\$2.04
Payment for Claim# 1234896[Rx# 0787899981996 Fill Date 20240227]	\$1.02	02/27/2024 05:02 PM	\$3.05
Payment for Claim# 1234895[Rx# 0787899981995 Fill Date 20240227]	\$1.02	02/27/2024 05:02 PM	\$2.03
Payment for Claim# 1234894[Rx# 0787899981994 Fill Date 20240227]	\$1.01	02/27/2024 05:01 PM	\$1.01

Showing 1 to 10 of 24 entries

Previous **1** 2 3 Next

Once you have selected **Manage Electronic Payments**, the user will be automatically taken right into the **Paynuver Microsite** where they can view their **EFT payment transaction history**, update their transfer options, view the account holder details, create new accounts (banks account for deposits), and return to the payment account

Paynover Microsite Functionality

Available Balance

\$0.00

- [Update Transfer Options](#)
- [Account Holder Details](#)
- [Return to Payment Account](#)

Accounts

BW Test *6789

+ Create Account

Transaction History

Name	Amount	Created	Balance
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:36 PM	\$0.00
Payment for Claim# 1234898[Rx# 0787899981998]Fill Date 20240227]	\$1.03	02/27/2024 05:36 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:05 PM	\$0.00
Payment for Claim# 1234897[Rx# 0787899981997]Fill Date 20240227]	\$1.03	02/27/2024 05:05 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$0.00
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$1.02
Automatic Disbursement from PA to ACH Transfer	(\$1.01)	02/27/2024 05:04 PM	\$2.04
Payment for Claim# 1234896[Rx# 0787899981996]Fill Date 20240227]	\$1.02	02/27/2024 05:02 PM	\$3.05
Payment for Claim# 1234895[Rx# 0787899981995]Fill Date 20240227]	\$1.02	02/27/2024 05:02 PM	\$2.03
Payment for Claim# 1234894[Rx# 0787899981994]Fill Date 20240227]	\$1.01	02/27/2024 05:01 PM	\$1.01

Showing 1 to 10 of 24 entries

Previous 1 2 3 Next

Current Transaction History displays as follows:

- Claim# XXXXXXXX|Rx# XXXXXXXXXXXXX|Fill Date XXXXXXXX

Pending enhancements to this page include:

- Patient Name added to each transaction record.(will be displayed after the Fill Date)
- The ability to export the Transaction History from the Paynover Microsite

Paynuver Microsite Functionality

Available Balance
\$0.00

[Update Transfer Options](#)
[Account Holder Details](#)
[Return to Payment Account](#)

Accounts

BW Test *6789

+ Create Account

Transaction History

Name	Amount	Created	Balance
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:36 PM	\$0.00
Payment for Claim# 1234898[Rx# 0787899981998]Fill Date 20240227	\$1.03	02/27/2024 05:36 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.03)	02/27/2024 05:05 PM	\$0.00
Payment for Claim# 1234897[Rx# 0787899981997]Fill Date 20240227	\$1.03	02/27/2024 05:05 PM	\$1.03
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$0.00
Automatic Disbursement from PA to ACH Transfer	(\$1.02)	02/27/2024 05:04 PM	\$1.02
Automatic Disbursement from PA to ACH Transfer	(\$1.01)	02/27/2024 05:04 PM	\$2.04
Payment for Claim# 1234896[Rx# 0787899981996]Fill Date 20240227	\$1.02	02/27/2024 05:02 PM	\$3.05
Payment for Claim# 1234895[Rx# 0787899981995]Fill Date 20240227	\$1.02	02/27/2024 05:02 PM	\$2.03
Payment for Claim# 1234894[Rx# 0787899981994]Fill Date 20240227	\$1.01	02/27/2024 05:01 PM	\$1.01

Showing 1 to 10 of 24 entries

Previous 1 2 3 Next

- **Once finished in the Paynuver Microsite, click on Return to Payment Account and the user will be brought back to the HCP Buy and Bill Portal Home Page**

Thank You

