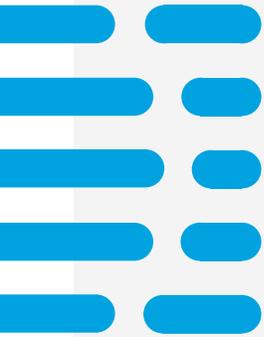




GSK PATIENT PORTAL USER GUIDE

Benlysta

July 2025



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Header/Footer Links



HEADER LINKS

Name	URL
Benlysta Logo	https://patient.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://patient.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



Welcome to the Benlysta Copay Portal

To submit a claim via the portal, you will need:

- A Benlysta Copay Portal account (create account)
- Information to verify your drug purchase

To submit a claim via mail or fax, you will need:

- Proof of payment showing out-of-pocket cost

Please note: You may only submit a claim if you have commercial insurance and you are not a participant of Medicare Part B, Medicare Part D, Medicaid, Medigap, VA, CHAMPUS, TriCare or other similar federal or state program.

Sign in

Email

Password [Forgot password?](#)

Remember my email

[Sign In](#) or create account

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Error Message

Welcome to the Benlysta Copay Portal

To submit a claim via the portal, you will need:

- A Benlysta Copay Portal account (create account)
- Information to verify your drug purchase

To submit a claim via mail or fax, you will need:

- Proof of payment showing out-of-pocket cost

Please note: You may only submit a claim if you have commercial insurance and you are not a participant of Medicare Part B, Medicare Part D, Medicaid, Medigap, VA, CHAMPUS, TriCare or other similar federal or state program.

Sign in

Email
Please enter your Email.

Password [Forgot password?](#)
Please enter your Password.

Remember my email

[Sign In](#) or create account

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Login Page



Forgot Password? -> Reset Your Password

Reset Your Password

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

Email Address

I'm not a robot

[Send Email](#)

Reset Your Password

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

Email Address

The Email Address field is required.

I'm not a robot

[Send Email](#)

Error Message

Reset Your Password: Password Reset Sent

Reset Your Password

✓ Password Reset Sent

Click the link in your email to reset your password.

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@benlystacopyprogram.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 Copay Portal account. You can also click here to receive a new link.

Your code will be valid for 30 minutes.

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Login Page



Reset Password: Email triggered using approved template

- Link brings user to this page

Error Messages

Reset Your Password

New Password

Confirm Password

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 ! @ # \$ % ^ & + =

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

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Reset Your Password

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 ! @ # \$ % ^ & + =

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

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Reset Your Password

New Password

New Password must be between 8 and 50 characters.

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 ! @ # \$ % ^ & + =

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

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Create Account



User has a card starting point

 **Benlysta**
(belimumab)
Subcutaneous 120 mg/100 mL
Subcutaneous 200 mg/100 mL

Enter Your Card Information

[Card Information](#) > [Verify Your Insurance](#) > [Personal Information](#) > [Create Your Account](#)

Welcome to the Benlysta Copay Portal. Please enter the RxGrp and RxID from your copay savings card below. If you do not already have a card, one will be issued to you when you complete registration.

RxGrp

RxID

[Next](#) [I don't have a card](#)

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 **Benlysta**
(belimumab)
Subcutaneous 120 mg/100 mL
Subcutaneous 200 mg/100 mL

Enter Your Card Information

[Card Information](#) > [Verify Your Insurance](#) > [Personal Information](#) > [Create Your Account](#)

Welcome to the Benlysta Copay Portal. Please enter the RxGrp and RxID from your copay savings card below. If you do not already have a card, one will be issued to you when you complete registration.

RxGrp

RxID

[Next](#) [I don't have a card](#)

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Create Account



Error Messages

Benlysta
(belimumab)
Biosimilarity to the Reference Product

Enter Your Card Information

[Card Information](#) > [Verify Your Insurance](#) > [Personal Information](#) > [Create Your Account](#)

Welcome to the Benlysta Copay Portal. Please enter the RxGrp and RxID from your copay savings card below. If you do not already have a card, one will be issued to you when you complete registration.

RxGrp

Please select your RxGrp.

RxID

Please enter your RxID.

[Next](#) [I don't have a card](#)

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Benlysta
(belimumab)
Biosimilarity to the Reference Product

Enter Your Card Information

[Card Information](#) > [Verify Your Insurance](#) > [Personal Information](#) > [Create Your Account](#)

Welcome to the Benlysta Copay Portal. Please enter the RxGrp and RxID from your copay savings card below. If you do not already have a card, one will be issued to you when you complete registration.

RxGrp

RxID

Card has not been activated. Please check your email for a message with the subject "Complete Your Co-pay Program Enrollment". If you cannot locate the email, call (800) 741-0375 or your prescribing physician's office for assistance.

[Next](#) [I don't have a card](#)

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Benlysta
(belimumab)
Biosimilarity to the Reference Product

Enter Your Card Information

[Card Information](#) > [Verify Your Insurance](#) > [Personal Information](#) > [Create Your Account](#)

Welcome to the Benlysta Copay Portal. Please enter the RxGrp and RxID from your copay savings card below. If you do not already have a card, one will be issued to you when you complete registration.

RxGrp

RxID

Invalid ID

[Next](#) [I don't have a card](#)

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Create Account



Complete account creation (either starting point)

Verify Your Insurance

User does not have a card starting point

Clicks I don't have a card

Benlysta (belimumab)
Subcutaneous (SC) 200 mg/10mL
Subcutaneous (SC) 200 mg/10mL

Enter Your Card Information

[Card Information](#) > [Verify Your Insurance](#) > [Personal Information](#) > [Create Your Account](#)

Welcome to the Benlysta Copay Portal. Please enter the RxGrp and RxID from your copay savings card below. If you do not already have a card, one will be issued to you when you complete registration.

RxGrp

RxID

[Next](#) [I don't have a card](#)

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Benlysta (belimumab)
Subcutaneous (SC) 200 mg/10mL
Subcutaneous (SC) 200 mg/10mL

Enter Your Insurance Information

[Card Information](#) > [Verify Your Insurance](#) > [Personal Information](#) > [Create Your Account](#)

We need to check your insurance information to make sure you're eligible for the program.
This program is not available to patients with government-funded insurance.

Prescription Insurance Name

BIN

Group

PCN (optional)

[Next](#)

Your Insurance Company
Subscriber name: Thomas Anderson
Identification number: XXXXXXXX000000
Group number: 00XXXX
RxBIN: 000000
RxCN: 00000000

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Create Account



Error Messages

Benlysta (belimumab)
Intravenous and subcutaneous injection 100 mg/100 mL
Subcutaneous injection 200 mg/100 mL

Enter Your Insurance Information

Card Information > **Verify Your Insurance** > Personal Information > Create Your Account

We need to check your insurance information to make sure you're eligible for the program.
This program is not available to patients with government-funded insurance.

Prescription Insurance Name

Please enter your Prescription Insurance Name.

BIN

Please enter your BIN.

Group

Please enter your Group.

PCN (optional)

Next

Your Insurance Company

Subscriber name Thomas Anderson	
Identification number XXXXXXXXXX	
Group number XXXXXX	Public service PCN XXXXXX

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Benlysta (belimumab)
Intravenous and subcutaneous injection 100 mg/100 mL
Subcutaneous injection 200 mg/100 mL

Enter Your Insurance Information

Card Information > **Verify Your Insurance** > Personal Information > Create Your Account

We need to check your insurance information to make sure you're eligible for the program.
This program is not available to patients with government-funded insurance.

Prescription Insurance Name

BIN

Group

PCN (optional)

Next

Your Insurance Company

Subscriber name Thomas Anderson	
Identification number XXXXXXXXXX	
Group number XXXXXX	Public service PCN XXXXXX

You are not eligible for the BENLYSTA Co-Pay Program at this time. Please contact support at 1-800-741-0375 for more information.

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Create Account



Personal Information (patient 18+ years old)

Enter Your Personal Information
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We need some personal information in order to submit your reimbursement claims.

First Name: [text input] Last Name: [text input]

Date of Birth: [mm/dd/yyyy] Gender: [Male] Phone: [Home] [Mobile]

Street Address: [text input]

Address Line 2 (optional): [text input]

City: [text input]

State: [dropdown] ZIP: [text input]

Copay Welcome Communication Preference: [SMS]

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

By checking this box and providing your mobile number, you agree to receive text messages from the Together with GSK Copay Program regarding your enrollment, including your welcome email and other GSK-related communications.
Message and data rates may apply. Message frequency may vary.
You may opt out at any time by replying STOP. For help, reply HELP.
Consent is not a condition of purchase or participation in the program.
You confirm that you are the authorized user of the mobile number provided and understand that your information will be handled in accordance with GSK's Privacy Policy.

Double Opt-In: SMS communication requires a double opt-in process to ensure patients explicitly agree to receive messages.

Claim Update Notifications
This is how you will receive communications about updates to the status of your claims.
 Email

Next

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Copay Welcome Communication Preference

[SMS] Smartcard Welcome

[SMS] text messages. Message and data rates may apply.

By checking this box and providing your mobile number, you agree to receive text messages from the Together with GSK Copay Program regarding your enrollment, including your welcome email and other GSK-related communications.
Message and data rates may apply. Message frequency may vary.
You may opt out at any time by replying STOP. For help, reply HELP.
Consent is not a condition of purchase or participation in the program.
You confirm that you are the authorized user of the mobile number provided and understand that your information will be handled in accordance with GSK's Privacy Policy.

Double Opt-In: SMS communication requires a double opt-in process to ensure patients explicitly agree to receive messages.

Copay Welcome Communication Preference

[Email] Smartcard Welcome

[SMS] text messages. Message and data rates may apply.

Error Messages

Enter Your Personal Information
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We need some personal information in order to submit your reimbursement claims.

First Name: [text input] Last Name: [text input]

Date of Birth: [mm/dd/yyyy] Gender: [Male] Phone: [Home] [Mobile]

Street Address: [text input]

Address Line 2 (optional): [text input]

City: [text input]

State: [dropdown] ZIP: [text input]

Claim Update Notifications
This is how you will receive communications about updates to the status of your claims.
 Email

Next

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Enter Your Personal Information
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We need some personal information in order to submit your reimbursement claims.

First Name: [text input] Last Name: [text input]

Date of Birth: [01/01/2000] Gender: [Female] Phone: [Home] [Mobile]

Street Address: [123 Main Street]

Address Line 2 (optional): [text input]

City: [text input]

State: [New Jersey] ZIP: [12345]

Claim Update Notifications
This is how you will receive communications about updates to the status of your claims.
 Email

Next

Patient already exists. Please contact support at 1-800-741-0375.

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Create Account



Personal Information

(patient under 18 years old + same address as caregiver)

Error Messages

Enter Your Personal Information
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We need some personal information in order to submit your reimbursement claims.

First Name: Last Name:

Date of Birth: Gender: Home Phone:

Street Address:

Address Line 2 (optional):

City:

State: ZIP:

Claim Update Notifications
This is how you will receive communications about updates to the status of your claims.
 Email

Caregiver First Name: Caregiver Last Name:

Caregiver Date of Birth: Same as patient

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Enter Your Personal Information
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We need some personal information in order to submit your reimbursement claims.

First Name: Last Name:

Date of Birth: Gender: Home Phone:

Street Address:

Address Line 2 (optional):

City:

State: ZIP:

Claim Update Notifications
This is how you will receive communications about updates to the status of your claims.
 Email

Caregiver First Name: Caregiver Last Name:

Caregiver Date of Birth: Same as patient

Caregiver Date of Birth must be between 1/1/1900 and 12/31/2005.

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Create Account



Personal Information

(patient under 18 years old + different address from caregiver)

Error Messages

Enter Your Personal Information
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We need some personal information in order to submit your reimbursement claims.

First Name: Last Name:
Date of Birth: Gender: Home Phone:
Street Address:
Address Line 2 (optional):
City:
State: ZIP:
Claim Update Notifications: Email
Caregiver First Name: Caregiver Last Name:
Caregiver Date of Birth: Caregiver Address: Same as patient
Caregiver Street Address:
Address Line 2 (optional):
City:
State: ZIP:

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Enter Your Personal Information
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We need some personal information in order to submit your reimbursement claims.

First Name: Last Name:
Date of Birth: Gender: Home Phone:
Street Address:
Address Line 2 (optional):
City:
State: ZIP:
Claim Update Notifications: Email
Caregiver First Name: Caregiver Last Name:
Caregiver Date of Birth: Caregiver Address: Same as patient
Caregiver Street Address:
Caregiver Street Address is required.
Address Line 2 (optional):
City:
City is required.
State: ZIP:
State is required. ZIP is required.

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Create Account



Create Your Account

Create Your Account
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We will use your email address and password to sign you into the Benlysta Copay Portal.

Email Address:

Password:

Confirm Password:

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 ! @ # \$ % ^ & * + =

Eligibility Questions

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

Are you 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 D, 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 eligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group health plan or government subsidized prescription drug benefits 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 (self-paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity or HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Are you a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?

Yes No

Are you commercially insured?

Yes No

Optional Opt-in for Additional Support

GSK offers helpful services and resources to support you on your treatment journey. Check the box below to utilize these services.

I agree to allow my doctor, pharmacist, or other healthcare provider to share my name, address, email address, and other information with GSK and companies working for or with GSK to contact you for marketing, market research, or advertising purposes, or to allow you to interact with GSK in other ways across multiple channels (eg, mail, email, website, online advertising, applications, and services), regarding the medical conditions in which you have expressed an interest, as well as other health-related information from GSK. GSK will not sell or transfer your name, address, or email address to any other party for their own marketing use. For additional information regarding how GSK handles your information, please see our privacy statement at [privacy.gsk.com/us](#).

Terms and Conditions

I agree to the BENLYSTA Copay Terms & Conditions.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

By my signature, I agree to allow my doctors, pharmacists, including my specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my health information to GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing services from BENLYSTA Gateway, which may include the following activities:

- Communicating with my Healthcare Providers about my BENLYSTA prescription and medical condition;
- Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for the Co-Pay Program for BENLYSTA or for the GSK Patient Assistance Program;
- Contacting my insurer, other potential funding sources, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds;
- Contacting me to offer (and, if I am interested, provide) optional educational services offered by healthcare professionals; and
- Disclosing my information to third parties if required by law.

By signing this authorization, I acknowledge my understanding that:

- My Healthcare Providers will not and may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on whether I sign this Patient Authorization.
- Certain Healthcare Providers, such as Specialty Pharmacies, may receive payment from GSK for disclosing my information to GSK as permitted by this authorization.
- Once information about me is released to GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent GSK from further disclosing my information. However, I understand that GSK has agreed to use or disclose information received only for the purposes described in this authorization or as required by law.
- This authorization will remain in effect for two (2) years after I sign it (unless a shorter period is required by state law) or for as long as I participate in the BENLYSTA Gateway program, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to P.O. Box 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in BENLYSTA Gateway program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date written revocation is received but will not apply to the extent that they have already taken action in reliance on this authorization. After this authorization is revoked, I understand that information provided to GSK prior to the revocation may be disclosed within GSK to maintain records of my participation.

The patient, or the patient's authorized representative, MUST sign this form to receive BENLYSTA Gateway services.

Your Name:

Relationship to Patient:

I'm not a robot

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View of Full Patient Authorization (content provided by GSK)

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

By my signature, I agree to allow my doctors, pharmacists, including my specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my health information to GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing services from BENLYSTA Gateway, which may include the following activities:

- Communicating with my Healthcare Providers about my BENLYSTA prescription and medical condition;
- Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for the Co-Pay Program for BENLYSTA or for the GSK Patient Assistance Program;
- Contacting my insurer, other potential funding sources, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds;
- Contacting me to offer (and, if I am interested, provide) optional educational services offered by healthcare professionals; and
- Disclosing my information to third parties if required by law.

By signing this authorization, I acknowledge my understanding that:

- My Healthcare Providers will not and may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on whether I sign this Patient Authorization.
- Certain Healthcare Providers, such as Specialty Pharmacies, may receive payment from GSK for disclosing my information to GSK as permitted by this authorization.
- Once information about me is released to GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent GSK from further disclosing my information. However, I understand that GSK has agreed to use or disclose information received only for the purposes described in this authorization or as required by law.
- This authorization will remain in effect for two (2) years after I sign it (unless a shorter period is required by state law) or for as long as I participate in the BENLYSTA Gateway program, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to P.O. Box 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in BENLYSTA Gateway program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date written revocation is received but will not apply to the extent that they have already taken action in reliance on this authorization. After this authorization is revoked, I understand that information provided to GSK prior to the revocation may be disclosed within GSK to maintain records of my participation.

The patient, or the patient's authorized representative, MUST sign this form to receive BENLYSTA Gateway services.

Error Messages

Create Your Account
Card Information > Verify Your Insurance > Personal Information > Create Your Account

We will use your email address and password to sign you into the Benlysta Copay Portal.

Email Address:

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 ! @ # \$ % ^ & * + =

Please enter your Email Address:

Password:

Please enter a Password:

Confirm Password:

The Confirm Password field is required.

Eligibility Questions

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

Are you enrolled in any of the following: Medicare, Medicaid, VA, DOD, or TRICARE?

Yes No

You are not eligible for the BENLYSTA Co-Pay Program at this time. Please contact Gateway to BENLYSTA for more information at 1-877-4BENLYSTA (1-877-422-6282).

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 D, 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 eligible for this program if they are Medicare eligible and enrolled in an employer-sponsored group health plan or government subsidized prescription drug benefits 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 (self-paying) patient. Those on Medicare Part D, even if in the coverage gap, are not eligible. Patients enrolled in private indemnity or HMO insurance plans that reimburse them for the entire cost of their prescription drugs are also not eligible.

Are you a resident of the US (including the District of Columbia, Puerto Rico, and the US Virgin Islands)?

Yes No

You are not eligible for the BENLYSTA Co-Pay Program at this time. Please contact Gateway to BENLYSTA for more information at 1-877-4BENLYSTA (1-877-422-6282).

Are you commercially insured?

Yes No

You are not eligible for the BENLYSTA Co-Pay Program at this time. Please contact Gateway to BENLYSTA for more information at 1-877-4BENLYSTA (1-877-422-6282).

Optional Opt-in for Additional Support

GSK offers helpful services and resources to support you on your treatment journey. Check the box below to utilize these services.

I agree to allow my doctor, pharmacist, or other healthcare provider to share my name, address, email address, and other information with GSK and companies working for or with GSK to contact you for marketing, market research, or advertising purposes, or to allow you to interact with GSK in other ways across multiple channels (eg, mail, email, website, online advertising, applications, and services), regarding the medical conditions in which you have expressed an interest, as well as other health-related information from GSK. GSK will not sell or transfer your name, address, or email address to any other party for their own marketing use. For additional information regarding how GSK handles your information, please see our privacy statement at [privacy.gsk.com/us](#).

Terms and Conditions

I agree to the BENLYSTA Copay Terms & Conditions.

Please agree to Benlysta and Conditions to proceed.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

By my signature, I agree to allow my doctors, pharmacists, including my specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my health information to GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing services from BENLYSTA Gateway, which may include the following activities:

- Communicating with my Healthcare Providers about my BENLYSTA prescription and medical condition;
- Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for the Co-Pay Program for BENLYSTA or for the GSK Patient Assistance Program;
- Contacting my insurer, other potential funding sources, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds;
- Contacting me to offer (and, if I am interested, provide) optional educational services offered by healthcare professionals; and
- Disclosing my information to third parties if required by law.

By signing this authorization, I acknowledge my understanding that:

- My Healthcare Providers will not and may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on whether I sign this Patient Authorization.
- Certain Healthcare Providers, such as Specialty Pharmacies, may receive payment from GSK for disclosing my information to GSK as permitted by this authorization.
- Once information about me is released to GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent GSK from further disclosing my information. However, I understand that GSK has agreed to use or disclose information received only for the purposes described in this authorization or as required by law.
- This authorization will remain in effect for two (2) years after I sign it (unless a shorter period is required by state law) or for as long as I participate in the BENLYSTA Gateway program, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to P.O. Box 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in BENLYSTA Gateway program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date written revocation is received but will not apply to the extent that they have already taken action in reliance on this authorization. After this authorization is revoked, I understand that information provided to GSK prior to the revocation may be disclosed within GSK to maintain records of my participation.

Your Name:

Relationship to Patient:

I'm not a robot

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Create Account



Account Created

Account Created

✔ **Your account has been created.**
Activate your account to sign in and begin submitting claims.

An email has been sent to you from donotreply@benlystacopayprogram.com. Click the link in that email to activate your account and sign in.

If you do not see the email, please check your junk mail folder. Be sure to add us to your Safe Senders list to ensure you continue to receive communications about your rebates.

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

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Account Created: Email triggered using approved template

Account Activated

Email triggered using approved template

Account Activated

✔ **Your account has been activated.**

[Click here](#) to sign in to the Benlysta Copay Portal.

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Home Page



No recent claims

Benlysta (belimumab) Submittance for 300 mg/150 mL
Submit a Claim My Account Contact Us JESSICA.RUBIN2@IQVIA.COM Sign Out

Welcome, JESSICA

[Submit a Claim](#)

Your reimbursements are mailed by check.

To receive your reimbursement immediately after your claim has been reviewed and processed, set up digital payment to a bank account or debit card. Your digital payments are managed on a secure payment site.

[Set up digital payment](#)

Claim History

You haven't submitted any claims yet.

[Submit a claim now](#)

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

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With recent claims

Benlysta (belimumab) Submittance for 300 mg/150 mL
Submit a Claim My Account Contact Us jrubin@us.imshealth.com Sign Out

Welcome, JESSICA

[Submit a Claim](#)

Your reimbursements are mailed by check.

To receive your reimbursement immediately after your claim has been reviewed and processed, set up digital payment to a bank account or debit card. Your digital payments are managed on a secure payment site.

[Set up digital payment](#)

Claim History

Date ▼	Status	Rebate Amount
7/25/2023	New Claim	

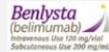
Need help?
Call Customer Support
(800) 741-0375
8:00 AM-8:00 PM ET Mon-Fri

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Home Page



Session Timeout



Welcome to the Benlysta Copay Portal

 Your session has been ended to protect your privacy.

To submit a claim via the portal, you will need:

- A Benlysta Copay Portal account ([create account](#))
- Information to verify your drug purchase

To submit a claim via mail or fax, you will need:

- Proof of payment showing out-of-pocket cost
- Cash register receipt

Please note: You may only submit a claim if you have commercial insurance or are self-insured, and you are not a participant of Medicare Part D, VA, TriCare, CHAMPUS, Medicaid, or any other similar federal or state program.

Sign in

Email

Password

[Forgot password?](#)

Remember my email

[Sign In](#) or [create account](#)

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My Account: Set Up Digital Payment (EFT)



- Clicking “Set up digital payment” brings up this window
- Clicking “Continue” brings patient to Transcard site to set up banking information for EFT

Benlysta (belimumab) | Submit a Claim | My Account | Contact Us | JESSICA.RUBIN2@IQVIA.COM | Sign Out

Welcome, JESSICA

[Submit a Claim](#)

☑ Your reimbursements are mailed to you. To receive your reimbursement immediately, you can set up digital payments to a bank account or debit card. Your digital payments are managed on a secure payment site.

[Set up digital payment](#)

Claim History

You haven't submitted any claims yet.

[Submit a claim now](#)

Connecting you to our secure payment site

You are leaving Benlysta Copay Portal to manage your digital payment. You can return at any time.

[Continue](#) [Cancel](#)

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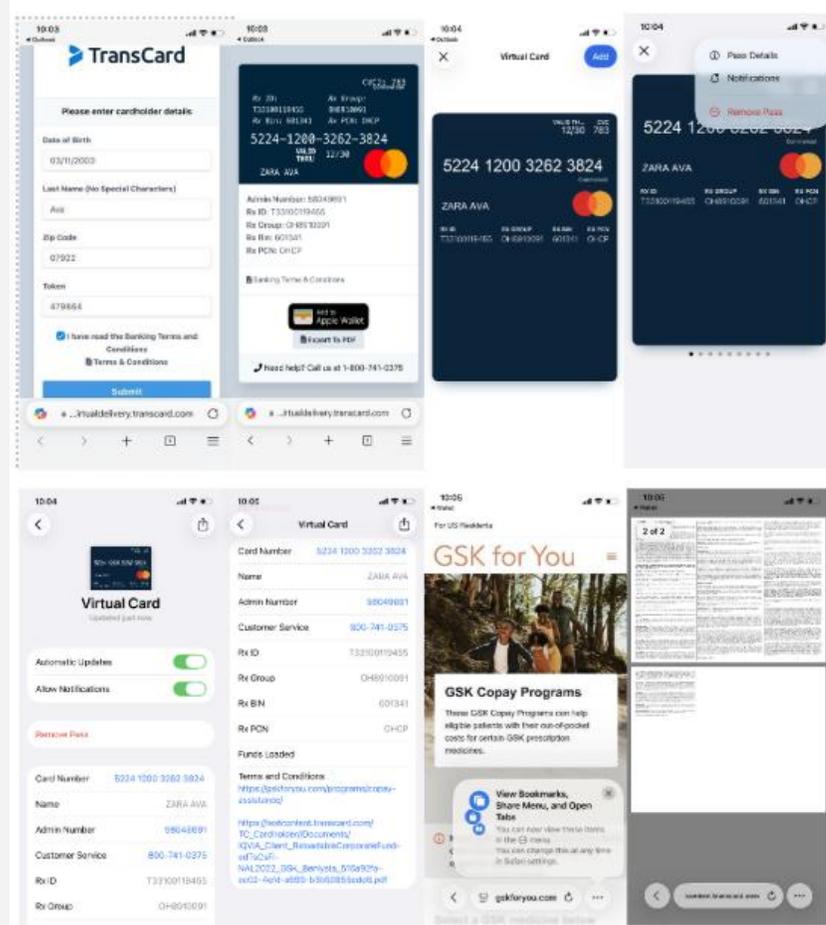
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My Account: Set Up Digital Payment (Mobile Wallet)

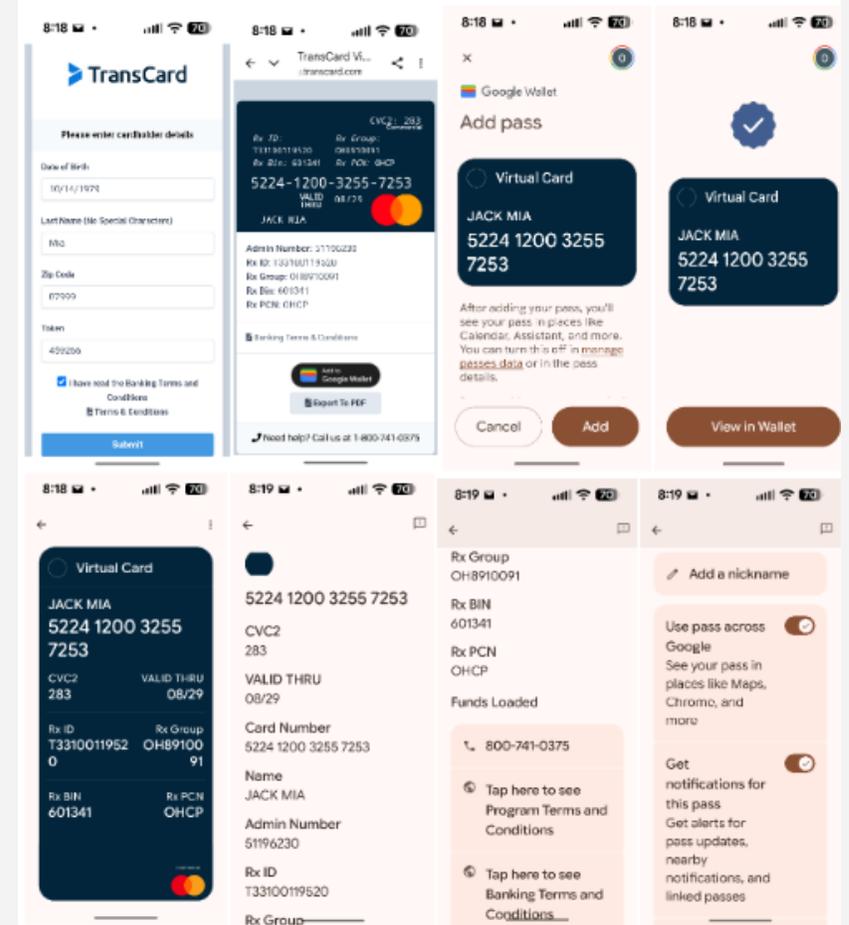


Add Your Copay Card to Your Mobile Wallet

Apple



Android



Navigation Menu: Submit a Claim



Other ways to submit a claim link points to Contact Us page

Pharmacy Selected

Benlysta (belimumab) Submit a Claim My Account Contact Us JESSICA.RUBIN2@IQVIA.COM Sign Out

Submit a Claim

To process your claim, we need to verify what you purchased and how much you paid.

Was this prescription filled at a pharmacy, or your prescriber's office?

Pharmacy Prescriber's Office

Pharmacy and cash register receipt should include the following information:

- Proof of payment establishing out-of-pocket cost
- NDC Number
- Rx Number
- Quantity
- Day Supply
- Prescription Price

Pharmacy Receipt

Register Receipt

Need help?

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

Please make sure your images are legible and clearly show the product purchased and the amount paid.

Files must be jpg, gif, tif, png, or pdf with a maximum size of 6 MB each.

[Other ways to submit a claim](#)

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Navigation Menu: Submit a Claim



Pharmacy Selected

Benlysta (belimumab) | Submit a Claim | My Account | Contact Us | JESSICA.RUBINZ@IQVIA.COM | Sign Out

Submit a Claim

To process your claim, we need to verify what you purchased and how much you paid.
Was this prescription filled at a pharmacy, or your prescriber's office?
 Pharmacy Prescriber's Office

Pharmacy and cash register receipt should include the following information:

- Proof of payment establishing out-of-pocket cost
- NDC Number
- Rx Number
- Quantity
- Day Supply
- Prescription Price

Pharmacy Receipt

Register Receipt

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Error Messages

Benlysta (belimumab) | Submit a Claim | My Account | Contact Us | JESSICA.RUBINZ@IQVIA.COM | Sign Out

Submit a Claim

To process your claim, we need to verify what you purchased and how much you paid.
Was this prescription filled at a pharmacy, or your prescriber's office?
 Pharmacy Prescriber's Office

Pharmacy and cash register receipt should include the following information:

- Proof of payment establishing out-of-pocket cost
- NDC Number
- Rx Number
- Quantity
- Day Supply
- Prescription Price

Pharmacy Receipt

Please select a file.

Register Receipt

Please select a file.

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Navigation Menu: Submit a Claim



Prescriber's Office Selected

Benlysta (belimumab) Injectables 120 mg/100 mL Belimumab 120 mg/100 mL Submit a Claim My Account Contact Us JESSICA.RUBIN2@IQVIA.COM
Sign Out

Submit a Claim

To process your claim, we need to verify what you purchased and how much you paid.

Was this prescription filled at a pharmacy, or your prescriber's office?

Pharmacy Prescriber's Office

EOB or Claims Remittance advice (EOP) should include the following information:

- 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
- HCP / Account seeking reimbursement
- Provider address

EOB or EOP

Have you already paid for the co-pay for this prescription out of your own pocket before submitting this co-pay claim?

Yes No

Need help?

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

Please make sure your images are legible and clearly show the product purchased and the amount paid.

Files must be jpg, gif, tif, png, or pdf with a maximum size of 6 MB each.

[Other ways to submit a claim](#)

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Navigation Menu: Submit a Claim



Prescriber's Office Selected

When “Yes” is selected, reimbursement will be sent via check or EFT (based on selection) upon successful claim processing

The screenshot shows the 'Submit a Claim' form with the following elements:

- Navigation: Submit a Claim, My Account, Contact Us
- Header: JESSICA.RUBINZ@IQVIA.COM, Sign Out
- Title: Submit a Claim
- Text: To process your claim, we need to verify what you purchased and how much you paid.
- Question: Was this prescription filled at a pharmacy, or your prescriber's office?
 Pharmacy Prescriber's Office
- Text: EOB or Claims Remittance advice (EOP) should include the following information:
 - 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
 - HCP / Account seeking reimbursement
 - Provider address
- Text: EOB or EOP
- Form: Attach File, Test Claim.pdf (with error icon)
- Text: Have you already paid for the co-pay for this prescription out of your own pocket before submitting this co-pay claim?
 Yes No
- Buttons: Submit, Cancel
- Footer: Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement, ©2023 IQVIA, GSK logo

When “No” is selected, SmartCard will be funded upon successful claim processing

The screenshot shows the 'Submit a Claim' form with the following elements:

- Navigation: Submit a Claim, My Account, Contact Us
- Header: JESSICA.RUBINZ@IQVIA.COM, Sign Out
- Title: Submit a Claim
- Text: To process your claim, we need to verify what you purchased and how much you paid.
- Question: Was this prescription filled at a pharmacy, or your prescriber's office?
 Pharmacy Prescriber's Office
- Text: EOB or Claims Remittance advice (EOP) should include the following information:
 - 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
 - HCP / Account seeking reimbursement
 - Provider address
- Text: EOB or EOP
- Form: Attach File, Test Claim.pdf (with error icon)
- Text: Have you already paid for the co-pay for this prescription out of your own pocket before submitting this co-pay claim?
 Yes No
- Buttons: Submit, Cancel
- Footer: Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement, ©2023 IQVIA, GSK logo

Navigation Menu: Submit a Claim



Error Messages

The screenshot shows the 'Submit a Claim' page with the following content:

- Navigation: Submit a Claim, My Account, Contact Us, JESSICA.RUBINZ@IQVIA.COM, Sign Out
- Section: **Submit a Claim**
- Text: To process your claim, we need to verify what you purchased and how much you paid. Was this prescription filled at a pharmacy, or your prescriber's office?
- Radio buttons: Pharmacy, Prescriber's Office
- Text: EOB or Claims Remittance advice (EOP) should include the following information:
- List of required information:
 - 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
 - HCP / Account seeking reimbursement
 - Provider address
- Text: EOB or EOP
- Form:
- Text: Please select a file.
- Text: Have you already paid for the co-pay for this prescription out of your own pocket before submitting this co-pay claim?
- Radio buttons: Yes, No
- Text: Please make a selection
- Buttons: Submit, Cancel
- Footer: Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement, ©2023 IQVIA, GSK logo

Claim Submitted

The screenshot shows the 'Claim Submitted' page with the following content:

- Navigation: Submit a Claim, My Account, Contact Us, JESSICA.RUBINZ@IQVIA.COM, Sign Out
- Section: **Claim Submitted**
- Text: **✓ Thanks! Your claim has been successfully submitted.**
- Text: Your confirmation number is 148545.
- Text: Once your claim has been approved, you should expect to receive your rebate in 2-3 business days.
- Text: Back to home page
- Footer: Privacy Policy | Terms of Use | Contact Us | GSK Copay Terms and Conditions | GSK Privacy Statement, ©2023 IQVIA, GSK logo

Claim Submitted: Email triggered using approved template

Navigation Menu: Submit a Claim



View Claim Details

Click claim date/status in Claim History list

Benlysta (belimumab) Submit a Claim My Account Contact Us JESSICA.RUBIN2@IQVIA.COM Sign Out

Claim Details

Confirmation Number	134392
Status	New Claim
Date Submitted	7/25/2023
Rebate Method	Debit
Card Group	OH8910091
Card ID	T33100102091

Attached Files

Test Claim.pdf

Close

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Claim Approved:

Email triggered using approved template

Claim Rejected:

Email triggered using approved template

Navigation Menu: My Account



My Account



[Submit a Claim](#)

[My Account](#)

[Contact Us](#)

JESSICA.RUBIN2@IQVIA.COM
[Sign Out](#)

My Account

Name

JESSICA RUBIN

Date of Birth

01/01/2000

Gender

Female

Home Phone

(333) 333-3333

Address

123 MAIN STREET

ANY, NJ 12345

Email Address

JESSICA.RUBIN2@IQVIA.COM

Claim Update Notifications

Email

[Edit](#)

[Change My Password](#)

My Insurance

BIN: 54635763

Group: 75833

PCN: 5378

[Edit Insurance](#)

My Reimbursement Method

Mailed by check

[Set up digital payment](#)

My Cards

Card Group	Card ID
------------	---------

OH8910091	T33100102091	SmartCard
-----------	--------------	---------------------------

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Navigation Menu: My Account



Edit Account

Account Contact Us

My Account

First Name: JESSICA Last Name: RUBIN

Date of Birth: 01/01/2000 Gender: Female Home Phone: (333) 333-3333

Street Address: 123 MAIN STREET

Address Line 2 (optional):

City: ANY

State: New Jersey ZIP: 12345

Email Address: JESSICA.RUBIN2@IQVIA.COM

Note: Changing your email address will also change your sign-in name.

Claim Update Notifications

This is how you will receive communications about updates to the status of your claims.

Email

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Benlysta (belimumab) Submit a Claim My Account Contact Us JESSICA.RUBIN2@IQVIA.COM Sign Out

My Account

Your account information has been updated.

Name: JESSICA RUBIN

Date of Birth: 01/01/2000 Gender: Female Home Phone: (333) 333-3333

Address: 123 MAIN STREET ANY, NH 12345

Email Address: JESSICA.RUBIN2@IQVIA.COM

Claim Update Notifications

Email

Change My Password

My Insurance

BIN: 54635763
Group: 75833
PCN: 5378

Edit Insurance

My Reimbursement Method

Mailed by check
Set up digital payment

My Cards

Card Group	Card ID
OH8910091	T33100102091 SmartCard

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Navigation Menu: My Account



Edit Insurance

My Account | Contact Us

Edit Insurance

Prescription Insurance Name

BIN

Group

PCN (optional)

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Benlysta (belimumab) | Submit a Claim | My Account | Contact Us

My Account

Your insurance information has been updated.

Name
JESSICA RUBIN

Date of Birth **Gender** **Home Phone**
01/01/2000 Female (333) 333-3333

Address
123 MAIN STREET
ANY, NH 12345

Email Address
JESSICA.RUBIN2@IQVIA.COM

Claim Update Notifications
 Email

Change My Password

My Insurance
BIN: 54635763
Group: 75833
PCN: 53789

Edit Insurance

My Reimbursement Method
 Mailed by check
[Set up digital payment](#)

My Cards
Card Group Card ID
OH8910091 T33100102091 SmartCard

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Navigation Menu: Starting and Remaining Balances



Benlysta (belimumab) [Submit a Claim](#) [My Account](#) [Contact Us](#)

Welcome, JESSICA

Copay Fund Balance:
\$15,000.00 of \$15,000.00

PLEASE NOTE: The starting and remaining balances are subject to change according to the program terms and conditions.

[Submit a Claim](#)

Your copay out-of-pocket expenses are mailed by check.
[Manage my copay out-of-pocket expense method](#)

Need help?
Call Customer Support
(800) 691-1939
8:00 AM-8:00 PM ET Mon-Fri

Claim History

Date ▼	Status	Rebate Amount
7/25/2023	New Claim	
7/25/2023	New Claim	
7/25/2023	New Claim	

Navigation Menu: My Account



When “SmartCard” is clicked

Clicking VIEW SMARTCARD button brings user to Transcard site (screenshots previously provided)

The screenshot shows the 'My Account' page for a user named JESSICA RUBIN. The page includes a navigation menu with 'Submit a Claim', 'My Account', and 'Contact Us'. A modal dialog box titled 'Connecting you to our secure payment site' is displayed in the foreground, containing the text: 'Your SmartCard will open in a new window, please use the security token below. Your Security Token is: 518432'. Below the token, there are two buttons: 'View SmartCard' and 'Close'. The background page shows personal information such as Name (JESSICA RUBIN), Date of Birth (01/01/2000), Address (123 MAIN STREET, ANY, NH 12345), and Email Address (JESSICA.RUBIN2@IQVIA.COM). There are also sections for 'My Reimbursement Method' (Mailed by check) and 'My Cards' (SmartCard).

Navigation Menu: My Account



Manage Reimbursement Method

Benlysta (belimumab) Submit a Claim My Account Contact Us

My Reimbursement Method

Your reimbursements are mailed by check.

Receive reimbursements by check
Checks are sent through mail and arrive 2-3 business days after your claim has been reviewed and processed.

Receive reimbursements by digital payment
This will stop reimbursements by check. Your change will take effect on your next submitted claim.
Funds are electronically transferred after your claim has been reviewed and processed. Any funds left in your payment account for over 90 days will be returned by check.
Manage digital payment
Change an account nickname, link a new bank account or debit card, transfer funds to a linked bank account or debit card.

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Benlysta (belimumab) Submit a Claim My Account Contact Us

My Reimbursement Method

Your reimbursements are mailed by check.

Receive reimbursements by check
Checks are sent through mail and arrive 2-3 business days after your claim has been reviewed and processed.

Receive reimbursements by digital payment
This will stop reimbursements by check. Your change will take effect on your next submitted claim.
Funds are electronically transferred after your claim has been reviewed and processed. Any funds left in your payment account for over 90 days will be returned by check.
Manage digital payment
Change an account nickname, link a new bank account or debit card, transfer funds to a linked bank account or debit card.

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Navigation Menu: My Account



Change Email Address

Benlysta (belimumab) | Submit a Claim | My Account | Contact Us

My Account

First Name: JESSICA | Last Name: RUBIN

Date of Birth: 01/01/2000 | Gender: Female | Home Phone: (333) 333-3333

Street Address: 123 MAIN STREET

Address Line 2 (optional):

City: ANY

State: New Jersey | ZIP: 12345

Email Address: Jessica.Rubin2@iqvia.com
Note: Changing your email address will also change your sign-in name.

Claim Update Notifications
This is how you will receive communications about updates to the status of your claims.

Email

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Benlysta (belimumab) | Submit a Claim | My Account | Contact Us

My Account

✔ Your account information has been updated.

Name: JESSICA RUBIN

Date of Birth: 01/01/2000 | Gender: Female | Home Phone: (333) 333-3333

Address: 123 MAIN STREET, ANY, NH 12345

Email Address: JRUBIN@US.IMSHEALTH.COM

Claim Update Notifications
 Email

Change My Password

My Insurance
BIN: 54635763
Group: 75833
PCN: 53789

My Reimbursement Method
 Mailed by check

My Cards
Card Group | Card ID
OH8910091 | T33100102091 | SmartCard

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Email Address Changed: Email triggered using approved template

Navigation Menu: My Account



Change Your Password

Benlysta (belimumab) Submit a Claim My Account Contact Us JESSICA.RUBINZ@IQVIA.COM Sign Out

Change Your Password

Old Password

New Password

Confirm Password

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 ! @ # \$ % ^ & + =

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Error Messages

Benlysta (belimumab) Submit a Claim My Account Contact Us JESSICA.RUBINZ@IQVIA.COM Sign Out

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 ! @ # \$ % ^ & + =

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Navigation Menu: My Account



Error Messages

The screenshot shows the 'Change Your Password' form with the following elements:

- Old Password:
- New Password: (highlighted in red)
- Confirm Password:
- Message: "New Password must be between 8 and 50 characters." (highlighted in red)
- Message: "Passwords must match." (highlighted in red)
- Buttons: "Save" (yellow) and "Cancel" (white)
- Requirements box: "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 ! @ # \$ % ^ & + ="

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The screenshot shows the 'Change Your Password' form with the following elements:

- Old Password:
- New Password:
- Confirm Password:
- Message: "New password does not meet the strength requirements." (highlighted in red)
- Buttons: "Save" (yellow) and "Cancel" (white)
- Requirements box: "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 ! @ # \$ % ^ & + ="

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Navigation Menu: My Account



Error Messages

Benlysta (belimumab) | Submit a Claim | My Account | Contact Us | JESSICA.RUBIN2@IQVIA.COM | Sign Out

Change Your Password

Old Password

The old password is incorrect.

New Password

Confirm Password

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 ! @ # \$ % ^ & + =

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Password Updated

Benlysta (belimumab) | Submit a Claim | My Account | Contact Us | Jessica.Rubin2@iqvia.com | Sign Out

My Account

Name
JESSICA RUBIN

Date of Birth 01/01/2000 **Gender** Female **Home Phone** (333) 333-3333

Address
123 MAIN STREET
ANY, NH 12345

Email Address
JESSICA.RUBIN2@IQVIA.COM

Claim Update Notifications
 Email

Change My Password

My Insurance
BIN: 54635763
Group: 75833
PCN: 53789
[Edit Insurance](#)

My Reimbursement Method
 Mailed by check
[Set up digital payment](#)

My Cards
Card Group Card ID
OH8910091 T33100102091 SmartCard

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