



GSK HCP PORTAL USER GUIDE

Specialty (Benlysta)

July 2025



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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 (EOB)
- 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

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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 (EOB)
- 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.

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Login Page



Forgot Password? -> [Reset Your Password](#)

Benlysta

(belimumab)

Intravenous (Iv) C1D mg/mL
Subcutaneous (sc) 200 mg/mL

[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
reCAPTCHA Privacy - Terms

Send Email

Need help?

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

Reset Your Password: Password Reset Sent



Home

Claims ▾

Practice ▾

Contact Us

Jessica.Rubin2@iqvia.com ▾

✓ 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 dontreply@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

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Login Page



Reset Password: Email triggered using approved template

- Link brings user to this page

 **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 ! @ # \$ % ^ & * = + -

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Change Your Password

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

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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Login Page



Error Message

Benlysta

(belimumab)

Immunosuppressant for Rheumatoid Arthritis and Systemic Lupus Erythematosus

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.

Save

Cancel

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)

Immunosuppressant for Rheumatoid Arthritis and Systemic Lupus Erythematosus

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Change Your Password

Old Password

New Password

Confirm Password

Passwords must match.

Save

Cancel

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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Benlysta

(belimumab)

Immunosuppressant for Rheumatoid Arthritis and Systemic Lupus Erythematosus

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Change Your Password

Old Password

New Password

Confirm Password

Passwords must match.

Save

Cancel

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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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

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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.

Jessica.Rubin2@iqvia.com

This email address is already in use.

First Name

Jessica

Last Name

Rubin

Phone Number

(333) 333-3333

Extension

Role in Practice

Office/Billing Administrator

Next

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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	Office/Billing Administrator		

Add a User

Next

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Register Your Practice



Clicking Add a User brings up this window

The screenshot shows the 'Create Practice Account' page with the 'Add a User' modal open. The modal contains the following fields and options:

- 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.
- Buttons: Save, Cancel

Error Message

The screenshot shows the 'Create Practice Account' page with the 'Add a User' modal open. The modal contains the following fields and options:

- Email Address: An activation email will be sent to this address. (Error: Email is required)
- First Name: (Error: First Name is required)
- Last Name: (Error: Last Name is required)
- Phone Number: (###) ###-####
- Extension
- Role in Practice: ☐ Administrator. Administrators can manage users and prescribers at the practice. (Error: User Role is required)
- Buttons: Save, Cancel

The screenshot shows the 'Create Practice Account' page with the 'Add a User' modal open. The modal contains the following fields and options:

- Email Address: An activation email will be sent to this address. (Error: This email address is already in use.)
- First Name: Jessica
- Last Name: Rubin
- Phone Number: (202) 333-3333
- Extension
- Role in Practice: ☒ Administrator. Administrators can manage users and prescribers at the practice.
- Buttons: Save, Cancel

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



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

NPI Number is required.

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	5555555555	New York	Edit

Add a Prescriber

Next

Error Messages

Register Your Practice



Clicking Add a Prescriber brings up this window

The screenshot shows the 'Create Practice Account' page with the 'Add a Prescriber' modal open. The modal has a purple header and contains the following fields:

- First Name:
- Last Name:
- NPI Number:
- State License Number (optional):

At the bottom of the modal are 'Save' and 'Cancel' buttons. The background page shows the 'Create Practice Account' form with a 'Next' button.

Error Messages

This screenshot shows the 'Add a Prescriber' modal with error messages for required fields. The fields and their error messages are:

- First Name: First Name is required.
- Last Name: Last Name is required.
- NPI Number: NPI Number is required.

The 'Save' button is disabled, and the 'Cancel' button is visible.

This screenshot shows the 'Add a Prescriber' modal with error messages for duplicate information. The fields and their error messages are:

- NPI Number: A prescriber with this NPI has already been added.
- State License Number (optional): A prescriber with this GH has already been added.

The 'Save' button is disabled, and the 'Cancel' button is visible.

Register Your Practice



Review Registration

Benlysta

Belimumab

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Create Practice Account

Review Registration

Please review the information below before submitting your registration.

Practice

Edit

TestBenlystaPractice

NPI: 5555555555

Tax ID: 44-4444444

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	Office/Billing Administrator
Jessica Rubin	jrubin@us.imshealth.com	Physician's Assistant

Prescribers

Edit

Name	NPI	SLN
TestDoc TestLast	5555555557	New York
TestDoc TestLast	5555555558	

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Practice Agreement

Benlysta

Belimumab

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Home | Claims | Practice | Contact Us

Jessica.Rubin2@iqvia.com

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

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Email triggered using approved template

Benlysta
(belimumab)
Intravenous Use 120 mg/100 mL
Subcutaneous Use 200 mg/mL

C-SH

Benlysta
Betaseron
Interferon beta-1a 0.625 mg
Subcutaneous Use Only

Benlysta
Belimumab

Navigation Menu (Home)



Portal Home Page (no recent claims)

Benlysta
(belimumab)
Prescription only. Use only with
instructions for use. See package insert for full prescribing information.

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Welcome, Jessica

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
You haven't submitted any claims yet.								

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Portal Home Page (with recent claims)

Benlysta
(belimumab)
Prescription only. Use only with
instructions for use. See package insert for full prescribing information.

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Welcome, Jessica

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

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Navigation Menu (Contact Us)





Contact Us

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

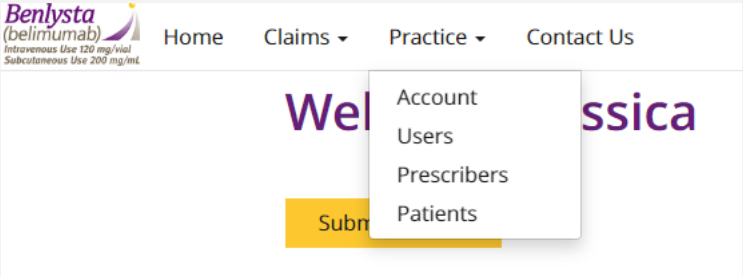
Customer Support
(800) 741-0375
8:00 AM – 8:00 PM ET Mon-Fri

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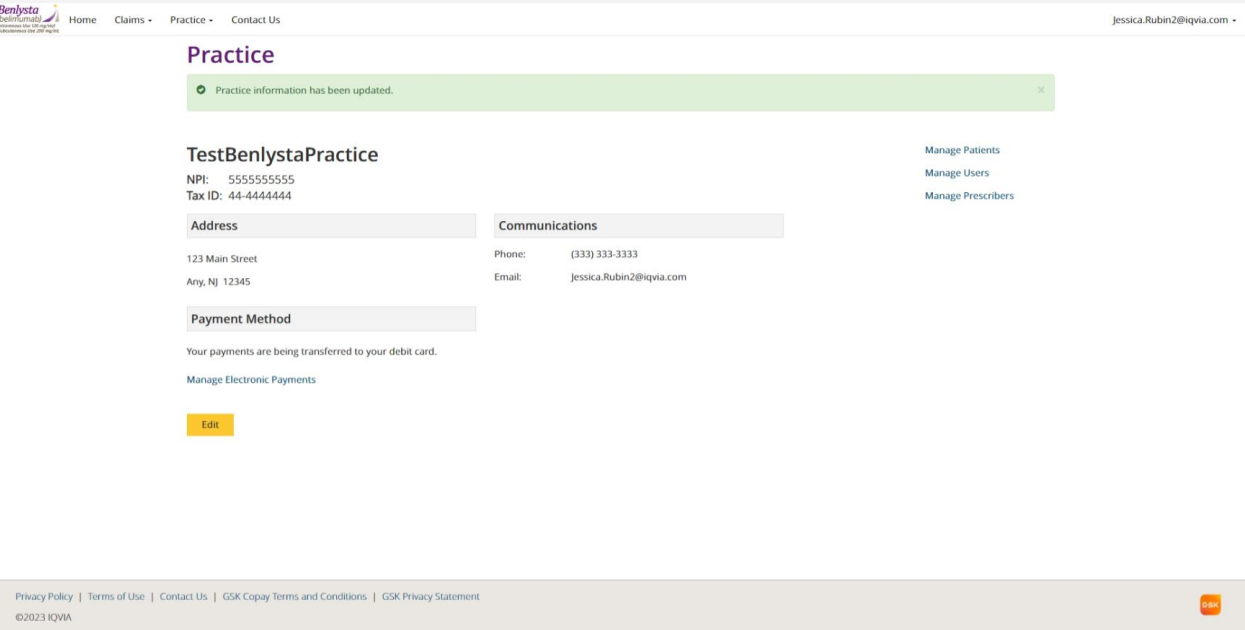
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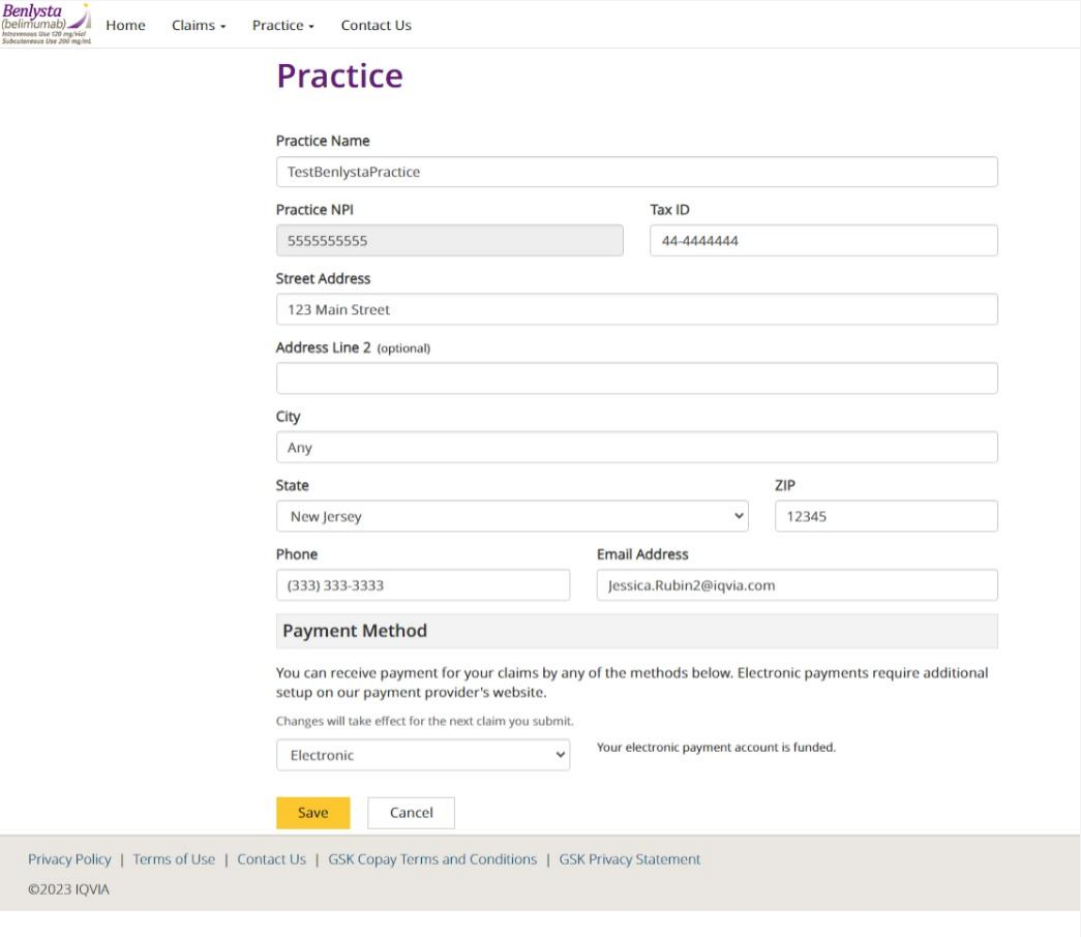
Navigation Menu (Practice -> Account)



Practice -> Account



Edit Practice



Navigation Menu (Practice -> Users)



Practice -> Users

Select Manage Users from Account Page or users from dropdown menu

Benlysta

belimumab

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Users

Add a User

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

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Add a User

Benlysta

belimumab

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Users

Add a User

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

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Email Address

An administrator email will be used to this address.

First Name

Last Name

Phone Number

Extension

Role in Practice

Administrator

Administrators can manage users and prescriptions at the practice.

Save

Cancel

Error Message

Benlysta

belimumab

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Users

Add a User

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

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Email Address

An administrator email will be used to this address.

First Name

Last Name

Phone Number

Extension

Role in Practice

Administrator

Administrators can manage users and prescriptions at the practice.

Save

Cancel

Edit User

Benlysta

belimumab

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Users

Add a User

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

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Email Address

An administrator email will be used to this address.

First Name

Last Name

Phone Number

Extension

Role in Practice

Administrator

Administrators can manage users and prescriptions at the practice.

Save

Cancel

Navigation Menu (Practice -> Prescribers)



Practice -> Prescribers

Select Prescribers Users from Account Page or prescribers from dropdown menu

Benlysta

belimumab

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Prescribers

Add a Prescriber

Name	NPI	SLN	
TestDoc TestLast	5555555557	New York	Edit
TestDoc TestLast	5555555558		Edit

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Add a Prescriber

Prescribers

Add a Prescriber

Name

TestDoc TestLast

TestDoc TestLast

First Name

Last Name

NPI Number

State License Number (optional)

Save

Cancel

Error Message

Prescribers

Add a Prescriber

Name

TestDoc TestLast

TestDoc TestLast

First Name

Last Name

NPI Number

State License Number (optional)

Save

Cancel

Edit Prescriber

Prescribers

Add a Prescriber

Name

TestDoc TestLast

TestDoc TestLast

First Name

Last Name

NPI Number

State License Number (optional)

Save

Cancel

Navigation Menu (Practice -> Patients)



Practice -> Patients

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

Benlysta
(belimumab)
Screening for CD4⁺ and
Subcutaneous (SC) mg/ml

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](#)

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GSK

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 [Search]

Add a Patient

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

No results

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Submit a Claim

Find a Patient

First Name: Last Name: [Search]

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

Please select the payment method for this claim.

Debit

Change default payment method.

Please provide the explanation of benefit for this claim.

- Patient cost share for the GSK drug.
- Patient cost share for administrative costs.
- Named patient who is covered by the Co-pay Program.
- GSK product name or the associated code.

Attach 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.

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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 has determined to be eligible for the Co-pay program. Other expenses, including but not limited to, out-of-network.

☐ Agree

Submit

Navigation Menu (Practice -> Patients)



Patient Record: View

Benlysta

Belimumab

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Submit a Claim

View SmartCard

Name

BENLN BENLN

Date of Birth

01/01/2000

Address

123 MAIN STREET
ANY, NJ 12345

Home Phone

(XXX) 333-3333

Email

JESSICA.RUBIN2@IQVIA.COM

Electronic Signature

✓ Consent received.

Co-pay Card GRP #

CH8910091

Co-pay Card ID #

133100101533

Gender

Female

Insurance Name

Test Player

Insurance BIN

57575757

Insurance Group

PACE

Insurance PCN

AJNB

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Patient Record: Edit

Benlysta

Belimumab

Home

Claims

Practice

Contact Us

Jessica.Rubin2@iqvia.com

Patient

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

(XXX) 333-3333

Email

JESSICA.RUBIN2@IQVIA.COM

Electronic Signature

✓ Consent received.

Co-pay Card GRP #

CH8910091

Co-pay Card ID #

133100101533

Insurance Name

Test Player

Insurance BIN

57575757

Insurance Group

PACE

Insurance PCN

AJNB

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Navigation Menu (Practice -> Patients)



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

Benlysta

Belimumab

HomeClaimsPracticeContact Us

Jessica.Rubin2@iqvia.com

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 #
NOCARDPN NOCARDLN	0H8910101	T34100100625
Date of Birth	Gender	
01/01/2000	Female	
Address	Insurance Name	
123 MAIN STREET	Test Payer	
ANY, NJ 12345	Insurance BIN	
Home Phone	22543634	
(333) 333-3333	Insurance Group	
Email	6757657	
JESSICA.RUBIN2@IQVIA.COM	Insurance PCN	
	76578567	

Electronic Signature

Awaiting online consent

Resend email

Edit

Close

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Patient Record: eConsent in place

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

Benlysta

Belimumab

HomeClaimsPracticeContact Us

Jessica.Rubin2@iqvia.com

Patient

Submit a Claim

View SmartCard

Name	Co-pay Card GRP #	Co-pay Card ID #
NOCARDPN NOCARDLN	0H8910101	T34100100625
Date of Birth	Gender	
01/01/2000	Female	
Address	Insurance Name	
123 MAIN STREET	Test Payer	
ANY, NJ 12345	Insurance BIN	
Home Phone	22543634	
(333) 333-3333	Insurance Group	
Email	6757657	
JESSICA.RUBIN2@IQVIA.COM	Insurance PCN	
	76578567	

Electronic Signature

Consent received.

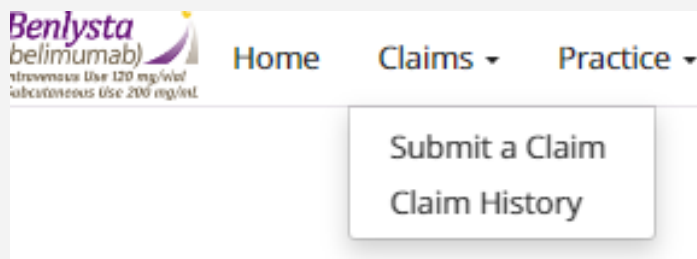
Edit

Close

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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

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

Submit a Claim

Patient New Patient Prescriber

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 (EOP), 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

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 Program has

☐ Agree

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Navigation Menu (Claims -> Submit a Claim)



Click on search icon to find patient

Benlysta (belimumab) Gateway

Home Claims Practice Contact Us

Jessica.Rubin2@iqvia.com

Submit a Claim

Patient Now Patient Prescriber

Need help?
Call Customer Support
(800) 741-6375
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 (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.

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.

☐ Agree

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Benlysta (belimumab) Gateway

Home Claims Practice Contact Us

Jessica.Rubin2@iqvia.com

Submit a Claim

Patient Now Patient Prescriber

Need help?
Call Customer Support
(800) 741-6375
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 (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

Find a Patient

First Name: Last Name:

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, co-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

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Navigation Menu (Claims -> Submit a Claim)



Find a Patient: Results

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

Submit a Claim

Patient: NOCARDIN NOCARDIN

Please select the payment method for this claim.

Debit

Change default payment method

Please provide the explanation of benefits (EOB) or Claims Remittance Advice (CRA), 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

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, Medicare, 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 this Co-pay program. Please ensure that the patient is not a resident of a state that is not participating in the program.

Agree

Submit

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Error Messages

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Submit a Claim

Patient: NOCARDIN NOCARDIN

New Patient: Prescriber: Prescription is required.

Please select the payment method for this claim.

Debit

Change default payment method

Please provide the explanation of benefits (EOB) or Claims Remittance Advice (CRA), 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

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, Medicare, 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 this Co-pay program. Please ensure that the patient is not a resident of a state that is not participating in the program.

Agree

Agreement is required.

Submit

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Navigation Menu (Claims)



Add a Patient (already has a card)

Benlysta
Belimumab (GSK)

Home Claims Practice Contact Us

Jessica.Rubin2@iqvia.com

Patient

First Name

Last Name

Does the patient have a card?
* Yes ☐ No ☐

Date of Birth

Gender

Co-pay Card GRP #

Co-pay Card ID #

Insurance Name

Insurance BIN

Insurance Group

Insurance PCN

Street Address

Address Line 2 (optional)

City

State

ZIP

Phone

* Home ☐ Mobile ☐

Email

Save Cancel

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Error Messages

Benlysta
Belimumab (GSK)

Home Claims Practice Contact Us

Jessica.Rubin2@iqvia.com

Patient

First Name

Last Name

Does the patient have a card?
* Yes ☐ No ☐

Date of Birth

Gender

Co-pay Card GRP #

Co-pay Card ID #

Insurance Name

Insurance BIN

Insurance Group

Insurance PCN

Street Address

Address Line 2 (optional)

City

State

ZIP

Phone

* Home ☐ Mobile ☐

Email

Save Cancel

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Navigation Menu (Claims)



Patient Added to Practice

Benlysta
(belimumab)
Interim use only
Subcutaneous Use Only

Home Claims Practice Contact Us

Jessica.Rubin2@iqvia.com

Patient

✔ Patient has been added.

Submit a Claim

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.

Edit

Close

View SmartCard

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

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Navigation Menu (Claims)



Enroll a Patient (does not have a card)

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

Patient

First Name	Last Name	Does the patient have a card? ☐ Yes ☒ No
Date of Birth	Gender	Co-pay Card GRP #
Street Address		Co-pay Card ID #
Address Line 2 (optional)		Insurance Name
City		Insurance BIN
State	ZIP	Insurance Group
Phone	☐ Home ☐ Mobile	Insurance PCN
Email		
Electronic Signature	The patient will receive an email requesting electronic signature	
Preferred Language (if other than English)		
Indication		
☐ 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, insurance, 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, 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		
Save Cancel		
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Error Messages

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

Patient

First Name	Last Name	Does the patient have a card? ☐ Yes ☒ No
Date of Birth	Gender	Co-pay Card GRP #
Street Address		Co-pay Card ID #
Address Line 2 (optional)		Insurance Name
City		Insurance BIN
State	ZIP	Insurance Group
Phone	☐ Home ☐ Mobile	Insurance PCN
Email		
Electronic Signature	The patient will receive an email requesting electronic signature	
Preferred Language (if other than English)		
Indication		
☐ 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, insurance, 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, 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		
Save Cancel		
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Navigation Menu (Claims)



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

Patient

First Name Last Name

City

State ZIP

Phone ☐ Home ☐ Mobile

Email

Electronic Signature

The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)

Indication

☐ 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 (1-877-423-6367).

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 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 (1-877-423-6367).

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 (1-877-423-6367).

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

Patient

First Name Last Name

City

State ZIP

Phone ☒ Home ☐ Mobile

Email

Electronic Signature

The patient will receive an email requesting electronic signature.

Preferred Language (if other than English)

Indication

☒ I agree to the BENLYSTA Co-pay 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, 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 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

The patient is already registered at your practice.

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Image updated 8/10/23 showing invalid response for eligibility.

Navigation Menu (Claims)




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[Practice](#)
[Contact Us](#)

anandappa.kuruba1@iqvia.com

Patient

First Name

Last Name

Date of Birth

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

Does the patient have a card?

☐ Yes
 ☒ No

Co-pay Card GRP #

CH8910101

Co-pay Card ID #

Insurance Name

Aetna

Insurance BIN

610502

Insurance Group

AP21

Insurance PCN

SE

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, co-insurance, 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.

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☐ Yes ☒ No

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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

Save

Cancel

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

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Home

Clinics

Practice

Contact Us

Jessica Rubin MD
OBGYN & Women's Health

Jessica.Rubin@mgale.com •

Patient

First Name

Last Name

Send FN

Send LN

Date of Birth

Gender

01/01/2000

Female

Street Address

123 Main Street

Address Line 2 (optional)

City

Anc

State

ZIP

New Jersey

12345

Phone

* Home ☐ Mobile

(333) 333-3333

Email

jessica.rubin@mgale.com

Save

Cancel

Does the patient have a card?

* Yes ☐ No

Co-pay Card GRP #

CH8910101

Co-pay Card ID #

5456456456

Group CardID is invalid.

Insurance Name

Test Paper

Insurance BIN

45642054

Insurance Group

6456

Insurance PCN

45654654

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Navigation Menu (Claims)



Government Insurance Detected

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

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

Patient

This patient is not eligible due to government insurance.

First Name BenLN	Last Name BenLN	Does the patient have a card? * Yes ☐ No ☐
Date of Birth 01/01/2000	Gender Female	Co-pay Card GRP # CH8910091
Street Address 123 Main Street		Co-pay Card ID # T33100101533
Address Line 2 (optional)		Insurance Name Test Payer
City Any		Insurance BIN 008589
State New Jersey	ZIP 12345	Insurance Group PACE
Phone (333) 333-3333	☒ Home ☐ Mobile	Insurance PCN AJNB
Email Jessica.Rubin2@iqvia.com		

This patient is not eligible due to government insurance.

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Enrollment Complete: eConsent Email Triggered to Patient using approved template

Patient Profile: Awaiting eConsent

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 NOCOSSENTYN NOCOSSENTLN	Co-pay Card GRP # CH8910101	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

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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?

OK

Cancel

Patient Profile: Awaiting Online Consent -> Resend email

Benlysta

Belimumab

HomeClaimsPracticeContact Us

Jessica.Rubin2@iqvia.com

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 #
NOCONSENTFN NOCONSENTLN	OH8910101	T34100100691
Date of Birth	Gender	
01/01/2000	Female	
Address	Insurance Name	
123 MAIN STREET	Test Payer	
ANY, NJ 12345	Insurance BIN	
Home Phone	12342343	
(333) 333-3333	Insurance Group	
Email	563546546	
JESSICA.RUBIN2@IQVIA.COM	Insurance PCN	
	757467564	
Electronic Signature		
Awaiting online consent Resend email Sent to 'JESSICA.RUBIN2@IQVIA.COM'		
Edit Close		

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Navigation Menu (Claims)



Submit Claim enabled once eConsent in place

Benlysta

HomeClaimsPracticeContact 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
NOCARDIN NOCARDIN	01/01/2000	12345	View Submit Claim
NOCORGENTIN NOCORGENTIN	01/01/2000	12345	View Submit Claim

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GSK Privacy Statement

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Submit a Claim (file attached and agree)

Benlysta

HomeClaimsPracticeContact Us

Jessica.Rubin2@iqvia.com

Submit a Claim

Patient

New Patient

Prescriber

NOCARDIN NOCARDIN

TestDoc TestLast

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

Attach FileTest 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

Agree

Submit

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Navigation Menu (Claims)



Claim Submitted

[Home](#) [Claims](#) [Practice](#) [Contact Us](#)

Jessica.Rubin2@iqvia.com

Claim Submitted

✔ The claim has been successfully submitted.

The confirmation number is 134370.

You will be notified once the claim is approved.

[Back to home page](#)

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Benlysta
(belimumab)

Patient → Starting and Remaining Balance

Nucala

(mepolizumab)

For oral use only

Home

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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

Name

Date of Birth

Address

Email

Edit

Close

Click here to access your patient's virtual copay card

Group

Member ID

Gender

Female

Insurance Type

☒ Prescription

☐ Medical

Insurance Name

Test Payer

Insurance BIN

2

Insurance Group

456

Insurance PCN

77

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

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

Benlysta

(belimumab)

Indicated for the treatment of Systemic Lupus Erythematosus (SLE) in adults

[Home](#)[Claims](#)

Practice

[Contact Us](#)

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

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

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

Benlysta

(belimumab)

Advances the field of systemic lupus erythematosus (SLE) treatment

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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 Paynuver Microsite from the HCP Buy and Bill Portal

Benlysta

Belimumab

Immunosuppressant

Indication for SLE and Sjögren's Syndrome

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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

Paynuver 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

Electronic Transfer Options

Dave Test Practice 1

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

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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

Paynuver Microsite Functionality

Electronic Transfer Options

Dave Test Practice 1

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

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- **Current Transaction History displays as follows:**

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

- **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 Paynuver Microsite

Paynuver Microsite Functionality

Electronic Transfer Options

Dave Test Practice 1

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

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1

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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