**GSK Patient Assistance Program**
PO Box 220590, Charlotte, NC 28222-0590
Phone: 1-866-728-4368, Fax: 1-855-474-3063
Monday – Friday 8am-8pm ET

## GSK Patient Assistance Program Application Check List:

**Call 1-866-728-4368 with any questions about how to complete this form**

The GSK Patient Assistance Program provides certain GSK medicines at no cost to eligible applicants. Eligibility is based on household income and insurance status. Residents of the United States, District of Columbia, and Puerto Rico may be eligible for both Vaccine and Non-Vaccine Medicines. Please be aware, this program does not constitute health insurance.

☐ **Complete all required sections of the application.** An incomplete application will delay processing.
- ♦ **All Applicants:** Complete sections 1, 2, 3, 8 **AND**
  - **Vaccine Applicants:** Complete sections 4 and 5.
  - **Non-Vaccine Applicants:** Complete sections 6 and 7.

☐ **Fax or mail the following:**
- ♦ **Completed and signed application.**
- ♦ **Signed prescription.** Signed original prescription(s) for GSK medication(s) written as medically appropriate. Note: Faxed prescriptions will only be accepted as valid if faxed directly from a physician's office and accompanied by a fax cover sheet. **All applications (vaccine and non-vaccine) must have a valid prescription submitted in order for product to be shipped.**
- ♦ **Medicare Part D applicants must also send:**
  - **Proof that they have spent $600 out-of-pocket on prescription medications.** Documentation includes all pages of the patient's most recent Medicare Part D prescription drug plan statement (Explanation of Benefits – EOB) indicating the patient has paid a total of $600 for prescriptions in the current calendar year. If the statement is not available, please call the GSK PAP at 1-866-728-4368 for help to identify other sources of proof.
    Note: The $600 expenditure can be co-pays, deductibles and direct costs for any prescription medication. The prescription expenses must not include monthly premiums or expenses of family members.
  - **A copy of their Medicare Part D prescription drug card. Please do not send original card(s).**

☐ Please keep a copy of the application and all documents for your record. **Do not send original documents as they will not be returned.**


- All required sections of the application need to be completed (see above).
- A valid prescription is required for all applications.

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**Patient Name:** _____ **Patient ID:** _____ **DOB:** _____

## Section 1: Applicant Information Required

Name (First):_____ (Last): _____ (M.I.): _____ Gender: M ☐ F ☐

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (____) _____-_____ Birth Date: _____/_____/_____ Social Security Number: _____
MM DD YYYY

If you would like to receive GSK patient assistance alerts, notifications and updates through email, please provide an email address.

Email: _____

Number of people, including applicant, who live in the household? _____ Number of people dependent on household income? _____

Total Gross Monthly Income: _____ or Gross Annual Income: _____

**GSK Medication(s) Requested**: _____

**Drug Allergies Required:** Do you have any known drug allergies? Yes ☐ No ☐

If Yes, list any known drug allergies: _____

_____

**Health Conditions Required:** Do you have any known health conditions? Yes ☐ No ☐

If Yes, list any known health conditions: _____

_____

## Section 2: Prescription Coverage Required

1. Does the applicant have prescription drug coverage through a Health Insurance Marketplace Plan/Exchange (also known as Affordable Care Act)? Yes ☐ No ☐
2. Is the applicant eligible for any state or federal (not including Medicare Part D) prescription drug coverage plan such as Medicaid? Yes ☐ No ☐
3. Does the applicant have any private prescription drug coverage (including employer sponsored plans, private group plans, etc.)? This does not include Medicare Part D drug coverage. Yes ☐ No ☐
   - If yes to question 3, please indicate why assistance is needed: _____
4. Is the applicant enrolled in a Medicare Part D prescription drug plan? Yes ☐ No ☐
   - If not, check no and skip to question number 5.
   - If yes, has the applicant spent $600 or more on prescription expenses since January 1st of the current calendar year?
     - If yes, please provide the patient's most recent Medicare Part D prescription drug plan statement (EOB) indicating the patient paid a total of $600 for prescriptions in the current calendar year.
     - **If no, please wait until the applicant has spent $600 or more on prescription expenses to apply.**
5. Is the applicant eligible for Puerto Rico's Government Healthcare Program, Mi Salud? Yes ☐ No ☐

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## Section 3: Authorized Individuals (optional)

For the patient: If you would like to give permission to GSK for other individuals (i.e. adult child, parent, friend) to conduct business on your behalf, please print their names here. Please note: These individuals are in addition to a legal guardian or registered advocate who may already be included on this application. **NOTE: Please make sure everyone who should be able to call in on your behalf is listed on the application, either as an authorized individual or provider/advocate. Otherwise, GSK Patient Assistance Program will not be able to release information to anyone other than the applicant.**

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

If you (the patient) or any of the above listed authorized individuals would like to receive GSK patient assistance alerts, notifications and updates through email, please provide an email address below.

Email Address: _____

## VACCINE PATIENTS ONLY

## Section 4: Shipping Address Required

### Required Replenishment Prescriber Shipping Address

**Prescriber Registration ID #:**_____

Prescriber must register for the Vaccines patient assistance program only. Enroll online at GSKPatientAssistanceProgramPortal.com. If there are any questions regarding the registration process, please call 1-866-728-4368.

**Prescriber Name:** _____ **SLN #:** _____ **Expiration Date:** _____

**DEA Number**: _____ Prescriber Email address: _____

Clinic Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (____) _____-_____ Fax Number: (____) _____-_____

Preferred Delivery Day: ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

## Section 5: Prescriber Information and Certification Required

My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive, and administer the requested medication(s) listed on this program enrollment form, shipped from GSK Patient Assistance Program (GSK PAP). I attest that the vaccine requested is indicated medically for the identified patient. I certify to the best of my knowledge, that the information on this application is correct and complete. I attest that the product I receive is a replacement of a previously purchased GSK vaccine. I also understand that eligibility under the program is subject to GSK's discretion and GSK reserves the right to modify or terminate the GSK PAP at any time. I represent that I have obtained all necessary authorizations, including a current and completed HIPAA Authorization Form, from my patient to allow me to release information to GSK and its contracted third parties.

My signature confirms that the vaccine product will be provided at no cost to the patient listed on this form and I understand that I am not eligible to seek reimbursement from any source for any medication provided by the GSK PAP. I understand that I will not receive reimbursement from GSK for the administration of this vaccine and further agree that I will not seek reimbursement for administration of the vaccine from any public payer.

**Prescriber Signature:** _____ Date: _____

*(Original signature required. Stamped signature not accepted.)*

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## NON-VACCINE PATIENTS ONLY

### Section 6: Advocate Information (optional)

Advocate ID #:_____ Email Address: _____

Register at www.GSKPatientAssistanceProgramPortal.com or by calling 1-866-728-4368

Facility Name: _____ First Name: _____ Last Name:_____ M.I.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (____) _____-_____ Fax Number: (____) _____-_____

By my signature, I certify to the best of my knowledge, the information on this application is correct and complete. I have no knowledge of, nor do I have any intent to, sell, barter or give this product to any person other than the Applicant for whom it has been prescribed. I have no knowledge, the Applicant has no medical/prescription insurance benefits for the indicated pharmaceutical(s), including Medicaid or other public programs other than as indicated, and the Applicant has insufficient financial resources to pay for the prescribed therapy.

**Advocate Signature:** _____ Date: _____
*(Original signature required. Stamped signature not accepted)*

If you would like to receive GSK patient assistance alerts, notifications and updates through email, please provide an email address.

Email: _____

### Section 7: Shipping Address (complete only if different than mailing address in Section 1)

Addressee or Business Name:
_____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (____) _____-_____ Fax Number: (____) _____-_____

Specify addressee's relationship to the applicant: ☐ Self ☐ Advocate (must complete Advocate Information in Section 6)
☐ Prescriber ☐ Other (specify relationship)
_____

**Refills Are Not Automatically Shipped. Please Visit Us Online Or Call Us To Request Your Refill.**

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## Section 8: Patient Certification Required

By my signature I authorize GSK, as well as Lash Group and any other companies that GSK uses to administer the GSK Patient Assistance Program (GSK PAP) (the "Program") to do the following:

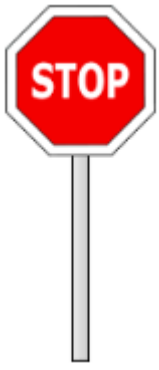
1) Use any information that I provide in my application for the purpose of helping me receive GSK products under the program or to administer the Program.
2) Receive and keep records of all prescriptions for the medications I receive under the Program, which will be used to administer the Program;
3) Contact my doctor, healthcare provider, or pharmacist about my application for the Program, and disclose to them information contained in my application, in order to help me receive GSK products under the Program and ensure that program guidelines are being met;
4) Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications I receive or will receive under the Program and about my medical condition. This information will be used only to determine my eligibility for the Program and to administer the Program;
5) Contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist;
6) Disclose any information obtained from the sources listed above to third parties if required by law.
7) Authorize GSK PAP and its Administrators to obtain a consumer report on me. My consumer report, and the information derived from public and other sources, will be used to estimate my income as part of the process to decide if I am eligible to receive free medication from GSK PAP. Upon request, GSK PAP will provide me the name and address of the consumer reporting agency that provides the consumer report.
8) Request additional documents and information at any time, even if I am already enrolled, so that they can decide if the information on this form is complete and true.

I understand that GSK does not charge a fee for participation in the Programs. If I have used a third party who charges a fee for help with my enrollment form or refills of my medicine, this money is not paid to GSK. I understand this Authorization to Release and Disclose Medical Information will remain in effect for as long as I participate in the Programs and for a period of 7 years after my participation in the Program ends. I understand my healthcare providers will not condition my medication treatment on my agreement to sign this Authorization to Release and Disclose Medical Information. I also understand that I have the right to revoke this authorization at any time by calling 1-866-728-4368, and mailing a signed written statement of my revocation to the Program. Such a revocation would end my eligibility to participate in the Program. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on my authorization. I understand that once medical information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed. I certify that the product I receive from GSK PAP is for my own use and will not be sold, bartered or given to any other person. I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify GSK of any change in my insurance eligibility or financial status.

**Patient or Legal Guardian Signature:** _____ Date: _____
*(Original signature required.)*

Printed Name (if other than Applicant): _____

Relationship (if other than Applicant): _____




## DID YOU REMEMBER……

- ✓ TO COMPLETE ALL SECTIONS OF THE APPLICATION?
- ✓ TO SIGN THE APPLICATION?
- ✓ TO SEND IN YOUR PROOF OF SPEND/ID CARD COPY? (Part D applicants only)
- ✓ TO OBTAIN A PRESCRIPTION FOR THE MEDICATION YOU'RE REQUESTING?