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 Vaccine Dose Authorization Request Form

Complete and fax this form to 1-855-474-3063

The GSK Patient Assistance Program was established to provide GSK vaccines to qualified patients. This form is to be used for patients already enrolled in the Program and who need subsequent doses of vaccine. Healthcare prescribers that purchase and administer these vaccines are eligible to register for the program. Please be aware, this program does not constitute health insurance. For additional information about eligibility requirements, program enrollment, and how to complete this form call 1-866-728-4368 M-F, 8:00 am – 8:00 pm ET. **Remember:** An incomplete Dosage Authorization Request form will delay processing. Call 1-866-728-4368 with questions about the form.

- ☐ **Complete and sign this form.**
- ☐ **Applicants: Must be ages 19 or older.**
- ☐ **Fax this completed form to 1-855-474-3063.**

Section 1: Applicant Information Required

Name (First):_____ (Last): _____ (M.I.): _____ Birth Date: _____/_____/_____
MM DD YYYY

Section 2: Prescriber Shipping Address for Vaccine Replenishment Required

Prescriber Registration ID #:_____

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

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

Phone Number: (____) _____-_____ Fax Number: (____) _____-_____ Preferred Delivery Day: ☐ Tues ☐ Wed ☐ Thu ☐ Fri

Section 3: Dose Release Required

58160-842-34 - Boostrix® Tetanus Toxoid, Reduced Diphtheria Toxid & Accellular Pertussis Vaccine, Absorbed	Dose 1 ☐				
58160-821-34 – Engerix-B® Hepatitis B Vaccine, Recombinant	Dose 1 ☐	Dose 2 ☐	Dose 3 ☐		
63851-501-02 - RabAvert® Rabies Vaccine for Human Use	Dose 1 ☐	Dose 2 ☐	Dose 3 ☐	Dose 4 ☐	Dose 5 ☐
58160-819-12 -Shingrix® Herpes Zoster Recombinant Subunit Vaccine	Dose 1 ☐	Dose 2 ☐			

Section 4: Prescriber 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 the 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 Dosage Authorization Request Form 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 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.)