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

GSK Patient Assistance Program Non-Vaccine Application

For questions on how to complete this form, call 1-866-728-4368.

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 to receive medicines through this program. Please be aware, this program does not constitute health insurance.

- ☐ **Complete all required sections of the application.** An incomplete application will delay processing.
- ☐ **Sign and date the last page of the application.**
- ☐ **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.
  - **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 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).**
  - **Medicare Beneficiary Identifier (MBI) field is required for Medicare Part D patients.**
- ☐ Please keep a copy of the application and all documents for your record.
- ☐ **Do not send original documents as they will not be returned.**

REMINDER

- **All required sections of the application need to be completed (see above).**
- **The application must be signed and dated.**
- **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: _____

Mailing Address:_____City:_____State:_____Zip: _____

Home Phone Number: (____)_____-_____ Cell Phone Number: (_____)_____-_____ Birth Date: _____/_____/_____

Email: _____

Medicare Beneficiary Identifier (MBI) - Medicare D patients only:_____

Household size: _____ Current annual household income: $_____

Does the applicant have any type of prescription drug coverage? Yes ☐ No ☐

If yes, please check the type(s) of coverage the patient has:

Medicare Part A/B ☐ Medicare Part D ☐ Medicaid ☐ Employer ☐ Marketplace/Exchange ☐ Private ☐ Mi Salud ☐
Other ☐_____

Drug Allergies: Do you have any known drug allergies? Yes ☐ No ☐
If Yes, list any known drug allergies: _____

Health Conditions: Do you have any known health conditions? Yes ☐ No ☐
If Yes, list any known health conditions: _____

Section 2: Authorized Individuals (Optional)

For the applicant: 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 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: _____

To prevent processing delays, don't forget to sign and date the last page of this application.

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Section 3: 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 4)
☐ Prescriber ☐Other (specify relationship) _ ___ ____ ___ ___ __

Section 4: Advocate Information (Optional)

Register at www.GSKPatientAssistanceProgramPortal.com

Advocate ID #:_____Facility Name:_____

First Name:_____Last Name:_____

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 are a healthcare provider and have a patient that needs assistance with a vaccine product, please visit www.gskforyou.com or www.gskpatientassistanceprogramportal.com to obtain a Vaccine Application. You can also call us at 1-866-728-4368 to request one be faxed to your office.

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Section 5: 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. For additional information about how GSK handles your information, please see our privacy notice at https://privacy.gsk.com/en-us.

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 Section 1 in its entirety?**
- **Sign and date the last page of the application?**
- **Include a prescription for the medication you are requesting?**
- **Send in a copy of your Proof of Spend and Part D ID Card? (Part D applications only)**

AN INCOMPLETE APPLICATION WILL RESULT IN PROCESSING DELAYS!