PO Box 52046 • Phoenix, AZ 85072-2046
Phone Number: 1-866-518-HELP (4357)
Fax Number: 1-866-518-3994
www.GSK-Access.com

GSK Access is a free program sponsored by GlaxoSmithKline that provides GlaxoSmithKline prescription medicines to Medicare Part D Prescription Plan enrollees who meet eligibility requirements.

YOU CAN APPLY IF:

- You are enrolled in a Medicare Part D Prescription Drug Plan
- You have spent at least $600 on prescription medications since January 1, 2012
- You live in one of the 50 states or the District of Columbia
- Your total household annual income is less than the amounts shown below

GSK Access Income Guidelines

Household Size	Annual Household Income*
1	less than $28,700
2	less than $38,500
3	less than $48,300
4	less than $58,100

***Annual household income amounts for Alaska and Hawaii are higher.**

Mail or fax the completed application, required documentation and a prescription(s) for your GSK medicine to:
GSK Access
PO Box 52046
Phoenix, AZ 85072-2046
Fax Number: 1-866-518-3994

NOTE: Faxed prescriptions are only valid if they are faxed directly from a physician's office. Faxed prescriptions received from any other location will not be accepted and will delay medication shipment. Drugs received from this program do not count toward True Out-of-Pocket Spending (TrOOP).

If you have any questions or for assistance completing the application, please call GSK Access toll-free at 1-866-518-HELP (4357) Monday through Friday 9:00 am to 7:00 pm Eastern Time and a customer service representative will be happy to talk to you.

Application Checklist

- ❑ **Fill out the application completely.** An incomplete application will delay processing.

- ❑ **Sign the application** on the signature line above.

- ❑ **Mail or fax the following, along with the application,** to the address or fax number at the top of page 1 of the application.
  - ♦ **A copy of the Medicare Part D Prescription Plan prescription drug card.** Do not send the original card.
  - ♦ **Proof that applicant has spent $600 or more in prescription medication** since January 1, 2012 from a statement from the pharmacy or the most recent Medicare Part D Plan Explanation of Benefits Statement.
  - ♦ **Proof of income.**
    - If federal income tax was filed, provide a copy of page one of the federal income tax form.
    - If the applicant did not file taxes, provide a copy of the most recent Social Security Benefit Statement for each member of the applicant's household.
  - ♦ **Signed prescription.** Signed original prescription(s) for GSK medication written for a 90-day supply with refills if medically appropriate.
    NOTE: Faxed prescriptions are only valid if they are faxed directly from a physician's office. Faxed prescriptions received from any other location will not be accepted and will delay medication shipment.

- ❑ **Be sure to print the applicant's name and date of birth** on each page submitted.

Please keep a copy of the application and all documents for your records.

GSK Access 2012 Application

Sections 1, 2, 4 and 5 are required

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SECTION 1 Applicant Information (Required)

Applicant Name (First):________________________ (Last):________________________ (M.I.):_____

Mailing Address:____

City:________________ State:_______ZIP Code:____________Phone number: (_______) _______ - ________

Social Security #: ☐☐☐-☐☐-☐☐☐☐ Birth Date:_______ /_______ /_______ (MM / DD / YYYY) Gender: M ❒ F ❒

☐ Number of people, including the applicant, who live in the household?

☐ Number of people dependent on the household income?

- Did the applicant file a federal income tax form or was the applicant listed as a dependent on someone else's federal income tax form for the most recent tax year?

  YES ❒ - If yes, enclose a copy of page one of the federal tax return. (Acceptable tax forms are 1040, 1040A, 1040EZ or 1040X only.)

  NO ❒ - If no, enclose a copy of the most recent Social Security Benefit Statement for each member of the applicant's household.

SECTION 2 Medicare Part D Prescription Drug Plan Information (Required)

- Is the applicant enrolled in a Medicare Part D Prescription Drug Plan?

  YES ❒ - If yes, enclose a copy of the applicant's Medicare Part D Plan prescription drug card (i.e.: MedicareRx card). Do not send the original card.

  NO ❒ - If no, the applicant is not eligible for GSK Access. Please call us to find out if the applicant qualifies for one of our other programs.

- Has the applicant spent $600 or more on prescription expenses since January 1, 2012?

Note: $600 expenditure can be copays, deductibles and direct costs for any prescription medication, not just GSK products. The prescription expenses must not include monthly premiums or expenses of family members.

  YES ❒ - If yes, enclose a printout from the pharmacy showing the applicant's name and a list of 2012 prescription expenses or a copy of the applicant's most recent explanation of benefits from the Medicare Part D prescription drug plan.

  NO ❒ - If no, the applicant is not eligible for GSK Access at this time. Please wait until the applicant has spent $600 or more on prescription expenses to apply to GSK Access.

SECTION 3 Shipping Address (If other than mailing address)

Addressee or Business Name: ____

Street Address: ____

City: ______________________________ State: __________ Zip Code: ____________

REQUIRED SIGNATURE ON PAGE 4

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SECTION 4 Prescription and Allergy/Health Information (Required)

Enclose an original signed prescription(s) for a GSK medication written for a 90-day supply with refills if medically appropriate.

List any known drug allergies:______________________________ Check box if none ❐

____

List any known health conditions: ______________________________ Check box if none ❐

____

SECTION 5 Patient Authorization to Release and Disclose Medical Information

By my signature I authorize GlaxoSmithKline, as well as McKesson Specialty Arizona Inc. (MSAZ) and any other companies that GlaxoSmithKline uses to administer GSK Access (the "Program"), to do the following:

1) Use any information that I provide in my application for the Program for the purpose of helping me receive GlaxoSmithKline 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 GlaxoSmithKline 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. By signing below, I also authorize my insurer, doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition that is requested by GlaxoSmithKline, MSAZ or any company that GlaxoSmithKline uses to run 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 Program 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.

I understand that GlaxoSmithKline does not charge a fee for participation in this Program. 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 GlaxoSmithKline.

I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I participate in the Program and for a period of 3 years after my participation in the Program ends.

I understand that my healthcare providers will not condition my medical 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 1-866-518-HELP (4357) 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 I am currently enrolled in a Medicare plan that includes Part D drug coverage. I certify that the product that I receive from the Program is for my own use and will not be sold, bartered or given to any other person. Furthermore, I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify GlaxoSmithKline of any change in my insurance eligibility or financial status.

Patient or Legal Guardian Signature ______________________________ ***Date*** ____________

Print Name ______________________________

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