BRIDGES to ACCESS®

BRIDGES TO ACCESS®
PO Box 29038, Phoenix, AZ 85038-9038
1.866.PATIENT (1.866.728.4368)
Fax:1.855.474.3063
www.BridgesToAccess.com

PATIENT ID #: 477116043

BRIDGES TO ACCESS® is a patient assistance program sponsored by GlaxoSmithKline that provides GlaxoSmithKline medicines to applicants who meet eligibility requirements. Eligibility is based on household income and insurance status. To apply, send a completed application along with income documentation and prescriptions for GlaxoSmithKline medication to the address or fax number above. Applicants will be notified by mail if they qualify for the program. If approved, the applicant will be eligible to receive medicine for up to one year and the first 90-day supply will be sent by mail. Applicants must re-apply annually. Additional information about eligibility requirements and how to complete this form can be obtained at www.BridgesToAccess.com or by calling 1.866.PATIENT.

APPLICANT INFORMATION (Required)

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

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? ☐

Total Gross Monthly Income: _____ **OR** Gross Annual 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, or tax form does not represent current income, enclose proof of income from all sources for the most recent 30-day period for the applicant and all members of the household. Include pay stubs, unemployment stubs, Social Security statements, pension statements, etc

PRESCRIPTION COVERAGE (Required)

1. Is the applicant eligible for any state or federal prescription drug program such as Medicaid? Yes ❒ No ❒
2. Does the applicant have any private prescription drug coverage? Yes ❒ No ❒

If yes to either of the above, please indicate why assistance is needed:

Medicine not on plan drug list ❒ *Pre-existing condition* ❒ *Over plan coverage limit* ❒

Other (please explain) ❒ _____

3. Is the applicant enrolled in a Medicare Part D prescription drug plan? Yes ❒ No ❒

SHIPPING ADDRESS Only complete this section if medicine is being shipped somewhere other than the Mailing Address above.

Addressee or Business Name:_____

Street Address:_____

City:_____ State:_____ ZIP Code:_____

Specify addressee's relationship to the applicant: Self ❒ Advocate ❒ (must complete Advocate Information on Page 2)

Other (specify relationship) ❒ _____

ALLERGY AND HEALTH INFORMATION (Required)

List any known drug allergies: _____ None ❒

List any known health conditions: _____ None ❒

AUTHORIZED INDIVIDUALS (Optional)

For the patient: if you would like to give permission to Bridges to Access 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:

First Name	Last Name	Relationship to patient

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REQUIRED SIGNATURE ON PAGE 2

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APPLICANT 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 Bridges to 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 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.PATIENT (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 understand that GlaxoSmithKline does not charge a fee for participation in this Program. There is a copayment for each prescription filled at a retail pharmacy. If my advocate charges a fee for enrollment or refills of my medicine, this money is not paid to GlaxoSmithKline.

I certify that I am not enrolled in any 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.

REQUIRED-PATIENT SIGNATURE

_____ _____ _____

Patient or Legal Guardian Signature | Date | Relationship (if other than Applicant)

OPTIONAL: ADVOCATE INFORMATION

This section should be completed only if the advocate enrolls the applicant and wants to be the contact person and receive program correspondence for this applicant.

Advocate ID Number: _____ (You must be a registered advocate. Register at www.BridgesToAccess.com or by calling 1.866.PATIENT)

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

Facility Name:_____

Street Address: _____

City:_____ State:_____ ZIP Code:_____

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. To the best of my 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.

REQUIRED-ADVOCATE SIGNATURE

_____ _____

Advocate Signature (Original signature required. Stamped signature not accepted.) | Date