Bridges to Access
PO Box 29038
Phoenix, AZ 85038-9038
1.866.PATIENT (1.866.728.4368)
www.BridgesToAccess.com

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 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

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

Mailing Address:_____

City:_____ State:_____ ZIP Code:_____ Phone Number: (_____) _____ - _____

Number of people, including the Applicant, who contribute to or are dependent on the household income? ☐

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

Total Gross Monthly Income: _____ **OR** Gross Annual Income: _____

If the applicant filed income tax or was listed as a dependent on someone else's income tax for the most recently filed tax year, attach a copy of page one of the tax form (acceptable tax forms are 1040, 1040A or 1040EZ only). If no tax form was filed or if the tax form does not represent current income, attach 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

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 ❒ Prescriber/Advocate ❒ (must complete Prescriber/Advocate Information on Page 2)

Other (specify relationship) ❒ _____

ALLERGY AND HEALTH INFORMATION

List any known drug allergies and health conditions: _____

_____

_____

REMEMBER TO:

- ❒ **Complete the entire form.** An incomplete application will delay processing. Call 1.866.PATIENT (1.866.728.4368) or visit www.BridgesToAccess.com with any questions about how to complete this form.
- ❒ **Mail the following:**
  - ◆ **Completed and signed application.**
  - ◆ **Proof of income.** If the applicant filed income tax or was listed as a dependent on someone else's income tax for the most recently filed tax year, attach a copy of page one of the tax form (acceptable tax forms are 1040, 1040A or 1040EZ only). If no tax form was filed or if the tax form does not represent current income, attach 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.
  - ◆ **Signed original prescription(s) for GlaxoSmithKline medication written for a 90-day supply with refills if medically appropriate.**
- ❒ **Keep a copy of the application and all documents for your records.** Please print applicant's name and date of birth on all documents.

REQUIRED SIGNATURE ON PAGE 2 P

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. 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.

_____ _____ _____

Applicant 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 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.

_____ _____

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