



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](http://www.BridgesToAccess.com) or by calling 1.866.PATIENT.

### APPLICANT INFORMATION

Name (First): \_\_\_\_\_ (M.I.): \_\_\_\_\_ (Last): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Social Security #:    -   -     Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ MM DD YYYY Gender: Race (Optional):  
 M  F

How many people, including the Applicant, contribute to or are dependent on the household income? \_\_\_\_\_

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. 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

Is the applicant eligible for any state or federal prescription drug program such as Medicaid? Yes  No

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)  \_\_\_\_\_

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](http://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. 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 prescription(s) for GlaxoSmithKline medication.**
- Keep a copy of the application and all documents for your records.** Please print applicant's name and date of birth on all documents.

