ENTER PRODUCT NAME

GSK Co-Pay Assistance Program
PO Box 220725
Charlotte, NC 28222-0725
1 .888.ONE.GSKCARES (1.888.663.4752)
Fax: 1.866.272.9439
www.CARESbyGSK.com

GSK Co-Pay Assistance Program is a patient assistance program sponsored by GlaxoSmithKline that helps eligible patients pay insurance copayments for certain GSK medicines. Eligibility is based on household income and insurance status. To apply, fax a completed application along with income documentation to 1.866.272.9439. Applicants will be notified if they qualify for the program. If approved, the patient will be responsible for paying the approved co-pay amount for each fill of the qualifying GSK medicine. The applicant's program co-pay ranges from $25 to $300, depending on the applicant's household income. Applicants with copayments or coinsurance that exceed 50% will be responsible for any remaining costs not covered by their insurance plan or the program. Applicants must re-apply annually. Additional information about eligibility requirements and how to complete this form can be obtained at www.CARESbyGSK.com or by calling 1 .888.ONE.GSKCARES (1.888.663.4752).

APPLICANT INFORMATION

Name (First): ______________ (M.I.): ______ (Last): ______________

Mailing Address: ______________

City: __________ State: ____ ZIP Code: ______ Day Time Phone Number: (   )   -

Best Time to Call: 9:00A-12:00P 12:00-3:00P 3:00-5:00P

Birth Date: ____ ____ ______ Gender: M F Preferred Language: ______________
MM DD YYYY

How many people, including the applicant, contribute to or are dependent on the applicant's 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

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

Is the applicant enrolled in a private prescription drug plan (not funded by a state or federal program) such as an employer sponsored plan or plan purchased on an individual basis? Yes No

If yes, complete the information below:

Primary Rx Insurer: ______________ Phone Number: (   )   -

Policy ID Number: ______________ Group Number: ______

Secondary Rx Insurer: ______________ Phone Number: (   )   -

Policy ID Number: ______________ Group Number: ______

PRESCRIBER INFORMATION

Name (First): ______________ (Last): ______________

Practice Name: ______________

Mailing Address: ______________ City: __________ State: ____ ZIP Code: ______

Practice Contact Name (First): ______________ (Last): ______________

Phone Number: (   )   - ______________ Fax Number: (   )   -

Preferred Specialty Pharmacy (if any) ______________

Has the prescription been submitted to a specialty pharmacy? Yes No

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PATIENT SIGNATURE REQUIRED ON PAGE 2

APPLICANT AUTHORIZATION TO RELEASE AND DISCLOSE MEDICAL INFORMATION

By my signature I authorize GlaxoSmithKline (GSK), as well as The Lash Group and any other companies that GlaxoSmithKline uses to administer the GSK Co-Pay Assistance Program (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 assistance with the copayment for 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 assistance with the copayment for GlaxoSmithKline products under the Program and ensure the Program guidelines are being met;

4) Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications for which I receive or will receive copayment assistance 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, Lash Group or any company that GlaxoSmithKline uses to run the Program;

5) 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 Medicare Information. I also understand that I have the right to revoke this authorization at any time by calling 1 .888.ONEGSKCARES (1.888.663.4752) 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.

I certify that I am not enrolled in any Medicare plan. 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)**

REMEMBER TO:

- **Complete the entire form.** An incomplete application will delay processing.
- **Fax the following to 1.866.272.9439:**
  - **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 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.
  - Call 1 .888.ONEGSKCARES (1.888.663.4752) or visit www.CARESbyGSK.com with any questions on how to complete this form.

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

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