

Thank you for downloading this patient assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER - Send your completed application to address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the "**Patient Savings**" tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low cost, and sliding scale medical and dental clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find nearly 2,000 cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. To date, our drug discount card has saved patients over \$244,000,000. Check out the next page to learn more.

Feel free to call our toll-free helpline if you have any questions. You can reach us at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thanks for using NeedyMeds! Please let us know if we can do anything else to help you afford the costs of your healthcare.



Richard J. Sagall, MD
President, NeedyMeds

Clip the card and save

 DRUG DISCOUNT CARD		NeedyMeds Drug Discount Card www.needymeds.org
BIN: 020750 RX PCN: NMeds RX GRP: PDFPDF ID: NMNA019309901930	Customer Care 1-888-602-2978	Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com . Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ. Pharmacy Help Desk: 1-800-404-1031.
This is a drug discount program, not an insurance plan.		

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family

- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

You can also save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
PO Box 219
Gloucester, MA 01931

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.



GSK Patient Assistance Program Non-Vaccine Application

For questions on how to complete this form, call 1-866-728-4368.

The GSK Patient Assistance Program provides certain GSK medicines at no cost to eligible applicants. Eligibility is based on household income and insurance status. Residents of the United States, District of Columbia, and Puerto Rico may be eligible to receive medicines through this program. Please be aware, this program does not constitute health insurance.

- ✓ **Complete all required sections of the application.** An incomplete application will delay processing.
- ✓ **Sign and date the last page of the application.**
- ✓ **Fax or mail the following:**
 - ◆ **Completed and signed application.**
 - ◆ **Signed prescription.** Signed original prescription(s) for GSK medication(s) written as medically appropriate.
 - Note: Faxed prescriptions will only be accepted as valid if faxed directly from a physician's office and accompanied by a fax cover sheet.
 - ◆ **Medicare Part D applicants must also send:**
 - **Proof that they have spent \$600 out-of-pocket on prescription medications.** Documentation includes all pages of the patient's most recent Medicare Part D prescription drug plan statement (Explanation of Benefits – EOB) indicating the patient has paid a total of \$600 for prescriptions in the current calendar year. If the statement is not available, please call the GSK PAP at 1-866-728-4368 for help to identify other sources of proof.

Note: The prescription expenses must not include monthly premiums or expenses of family members.
 - **A copy of their Medicare Part D prescription drug card. Please do not send original card(s).**
- ✓ Please keep a copy of the application and all documents for your record.
- ✓ **Do not send original documents as they will not be returned.**

REMINDER

- **All required sections of the application need to be completed (see above).**
- **The application must be signed and dated.**
- **A valid prescription is required for all applications.**



Patient Name: _____ **Patient ID:** _____ **DOB:** _____

Section 1: Applicant Information (Required)

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

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (____) _____ - _____ Birth Date: ____/____/____ Social Security Number: _____

Household size: _____ Current annual household income: \$ _____

Does the applicant have any type of prescription drug coverage? Yes No

If yes, please check the type(s) of coverage the patient has:

Medicare Part A/B Medicare Part D Medicaid Employer Marketplace/Exchange Private Mi Salud
Other _____

Drug Allergies: Do you have any known drug allergies? Yes No

If Yes, list any known drug allergies: _____

Health Conditions: Do you have any known health conditions? Yes No

If Yes, list any known health conditions: _____

Section 2: Authorized Individuals (Optional)

For the applicant: If you would like to give permission to GSK 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. **NOTE: Please make sure everyone who should be able to call in on your behalf is listed on the application, either as an authorized individual or advocate. Otherwise, GSK Patient Assistance Program will not be able to release information to anyone other than the applicant.**

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

To prevent processing delays, don't forget to sign and date the last page of this application.



Patient Name: _____ **Patient ID:** _____ **DOB:** _____

Section 3: Shipping Address
(Complete ONLY if different than mailing address in Section 1)

Addressee or Business Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

Specify addressee's relationship to the applicant: Self Advocate (must complete Advocate Information in Section 4)
 Prescriber Other (specify relationship) _____

Section 4: Advocate Information (Optional)

Register at www.GSKPatientAssistanceProgramPortal.com

Advocate ID #: _____ Facility Name: _____

First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary 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. I have no 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: _____ **Date:** _____
(Original signature required. Stamped signature not accepted)

If you are a healthcare provider and have a patient that needs assistance with a vaccine product, please visit www.gskforyou.com or www.gskpatientassistanceprogramportal.com to obtain a Vaccine Application. You can also call us at 1-866-728-4368 to request one be faxed to your office.



Patient Name: _____ **Patient ID:** _____ **DOB:** _____

Section 5: Patient Certification (Required)

By my signature I authorize GSK, as well as Lash Group and any other companies that GSK uses to administer the GSK Patient Assistance Program (GSK PAP) (the "Program") to do the following:

- 1) Use any information that I provide in my application for the purpose of helping me receive GSK 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 GSK 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;
- 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 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.
- 7) Authorize GSK PAP and its Administrators to obtain a consumer report on me. My consumer report, and the information derived from public and other sources, will be used to estimate my income as part of the process to decide if I am eligible to receive free medication from GSK PAP. Upon request, GSK PAP will provide me the name and address of the consumer reporting agency that provides the consumer report.
- 8) Request additional documents and information at any time, even if I am already enrolled, so that they can decide if the information on this form is complete and true.

I understand that GSK does not charge a fee for participation in the Programs. 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 GSK. I understand this Authorization to Release and Disclose Medical Information will remain in effect for as long as I participate in the Programs and for a period of 7 years after my participation in the Program ends. I understand my healthcare providers will not condition my medication 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 1-866-728-4368, 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 certify that the product I receive from GSK PAP is for my own use and will not be sold, bartered or given to any other person. I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify GSK of any change in my insurance eligibility or financial status.

Patient or Legal Guardian Signature: _____ **Date:** _____
(Original signature required.)

Printed Name (if other than Applicant): _____

Relationship (if other than Applicant): _____

DID YOU REMEMBER TO.....



- Complete Section 1 in its entirety?
- Sign and date the last page of the application?
- Include a prescription for the medication you are requesting?
- Send in a copy of your Proof of Spend and Part D ID Card? (Part D applications only)

AN INCOMPLETE APPLICATION WILL RESULT IN PROCESSING DELAYS!