



Instructions for Completing the Enrollment Form for Reimbursement and Access Support

To enroll your patients who have been prescribed an oral oncology and/or specialty medication from GSK, please complete the following form.

It is not necessary to complete the entire form.

Complete those sections of the form that correspond to the services that you would like to receive:

- **Distribution Support Service** - To receive distribution support services, please complete sections A through D.
- **Reimbursement Support Service** - To receive reimbursement support services, please complete sections A, B, C, and E.
- **Patient Support Service** - To receive patient support services, please complete sections A and F. The program is designed to support you and educate you on the product. This program is not available for all oral oncology medications. Please contact your GSK representative to learn more details.
- **GSK Co-Pay Assistance Program** - To receive co-pay assistance, the patient must enroll by completing sections A, B, C, and G. In addition, the patient must also provide income documentation.



www.CARESbyGSK.com

1-888-ONE-GSKCARES

(1 - 8 8 8 - 6 6 3 - 4 7 5 2)



Program Enrollment Form
www.CARESbyGSK.com
(888) ONE-GSKCARES
(888) 663-4752

Identify Patient's Therapy

Please complete the enrollment form and patient authorization section.
Once completed, fax to **866-272-9439**.

Patient Information

Patient Name: _____ Date of Birth: _____ / _____ / _____ Preferred Language: _____
Address: _____ Phone (Home): _____
(Work): _____ (Cell): _____ (Alternate) Contact: _____

Physician Information

Physician Name: _____ Site Name: _____ Site Contact Name: _____
Address: _____ Phone: _____
Fax: _____
Tax ID #: _____ Payer-Specific ID #: _____
NPI #: _____

PATIENT CONSENT/AUTHORIZATION: I verify that the information provided herein is true and correct. I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance information, and prescription/medical information, is "protected health information." See Page 2 of 3 for more information. By signing below, I agree to the collection, use, and disclosure of my protected health information to coordinate the delivery of medication to me.

Signature of Patient or Patient Representative: _____ **Sign Here**
Name (print): _____ Date: _____ / _____ / _____
Relationship (if other than patient): _____

Clinical Information Diagnosis & ICD-9 Codes: _____ Previous Therapy: _____

Insurance

Primary Insurer: _____ Phone: _____
Policy ID #: _____ Group #: _____
Subscriber Name: _____ Date of Birth: _____ / _____ / _____
Secondary Insurer: _____ Phone: _____
Policy ID #: _____ Group #: _____
Subscriber Name: _____ Date of Birth: _____ / _____ / _____

Prescription Information

Dosage: _____ Quantity: _____
Refills: _____ State Lic #: _____
DEA #: _____
Dosing Instructions (Sig): _____ Date: _____ / _____ / _____

PHYSICIAN DECLARATION: I certify that I am prescribing the drug listed above for the patient listed above. I authorize the CARES by GSK program, operated by the Lash Group, an agent of GlaxoSmithKline, to transmit electronically or otherwise, on my behalf, this prescription to the authorized specialty pharmacy of the patient's choice as indicated above. I understand that the dispensing specialty pharmacy shall send the medication to the patient, unless the patient prefers it to be sent to me, in which case I shall deliver it to the patient. I agree that I will not seek reimbursement for any medication provided hereunder from any government program or third-party insurer.

Physician Signature (no stamps): _____ **Sign Here**
Name (print): _____ Date: _____

Prescription Fulfillment

Will drug be dispensed from your facility? Yes No (continue below)

Specialty Pharmacy

Product is available from multiple **authorized** specialty pharmacies through the CARES by GSK program. A complete list of **authorized** specialty pharmacies is available at www.CARESbyGSK.com. Unless the patient requests otherwise, the prescription will be directed to the **authorized** specialty pharmacy that provides the lowest cost-sharing for the patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected for the patient based on uniformly applied selection criteria.

- No preference. Please direct prescription to the authorized specialty pharmacy that provides the lowest cost-sharing option for the patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected based on uniformly applied selection criteria.
- Please direct the prescription to the following authorized specialty pharmacy provided that this specialty pharmacy offers the lowest cost-sharing option for the patient: _____

(Note: If a specialty pharmacy is found to offer a lower cost-sharing option for the patient than the specialty pharmacy named above, the prescription will be directed to the specialty pharmacy offering the patient the benefit of a lower cost.)

Where would you like your patient's product sent via express delivery?

- Directly to my patient at the address listed above. To my office at the address listed above.
 Other address if the address listed above is a post office box: _____

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, prescription, and medical information, is “protected health information.” By signing below, I agree to the collection, use, and disclosure of my protected health information as described below.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this Patient Authorization and Release. I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to use or disclose information they receive only for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for two (2) years or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer.

I also understand that I have the right to revoke this authorization at any time by calling 1-866-489-5372 and mailing a signed, written statement of my revocation to PO Box 220225, Charlotte, NC 28222-0265, but that such a revocation would end my eligibility to participate in the programs as described. 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 this authorization. This means that, after you revoke this authorization, your information may be disclosed among GlaxoSmithKline (“GSK”) and the company or companies that help GSK administer the programs in order to maintain records of your participation, but it will not be otherwise disclosed or used.

Enrollment in CARES by GSK (for reimbursement support and assistance)

The patient, or the patient’s authorized representative, MUST sign this form in order to receive reimbursement support and assistance from the CARES by GSK program. Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release. If an authorized representative signs for the patient, please indicate relationship to the patient.

By signing below, I authorize GSK, as well as the Lash Group and any other companies that GSK uses to administer CARES by GSK, to do the following:

- 1) Request and receive information from my doctor, healthcare provider, health insurer, or pharmacist necessary to investigate and resolve my coverage, coding, or reimbursement inquiry;
- 2) Collect, use, and disclose to each other any information that I provide to CARES by GSK for the purpose of investigating and resolving my coverage, coding, or reimbursement inquiry or to administer CARES by GSK;
- 3) Disclose information to my treating physician, healthcare professional, or pharmacist that I have provided to CARES by GSK as necessary to resolve my coverage, coding, or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by GSK and the Lash Group;
- 4) Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs (eg, GSK’s *Commitment to Access* Program) on my behalf to determine if I am eligible for health insurance coverage or other funds, and disclose to them information about my prescribed medications and medical condition that has been provided by me or my physician, healthcare provider, or pharmacist; and
- 5) Disclose any information obtained from the sources listed above to third parties if required by law.

Patient Name (print): _____ Date: _____

Signature of Patient or Patient Representative: _____ 

Relationship (if other than patient): _____


ENROLLMENT IN CARES BY GSK PATIENT SUPPORT PROGRAM

The patient, or the patient’s authorized representative, MUST sign this patient support program (“support program”) form. The support program is designed to support you and educate you on the product. Before signing, you, the patient, should review, understand and agree to the terms of this authorization and release. If an authorized representative signs for the patient, please indicate relationship to the patient.

By signing, I authorize GSK, as well as the Lash Group and any other companies that GSK uses to administer the support program, to do the following:

- 1) Contact me via telephone (including voicemail, e-mail, or mail) with information about this support program, including providing information about product and information about support with my medication and medications in general;
- 2) Collect, use, and disclose any information that I have provided to GSK or any of the companies administering the support program for the purpose of providing me with information, contacting me, and otherwise administering such program;
- 3) Market and advertise to me regarding my medical condition, as well as provide me with other general health-related information;
- 4) Contact and disclose information about me to, and receive information about me from, my treating physician, healthcare professional, or pharmacist for purposes of administering this support program. By signing below, I also authorize my doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by GSK, as well as the Lash Group and any other companies that GSK uses to administer the support program;
- 5) Disclose any information obtained from the sources listed above to third parties if required by law; and
- 6) Use such information to review, analyze, improve, and measure the effectiveness of the support program.

Patient Name (print): _____ Date: _____

Signature of Patient or Patient Representative: _____ 

Relationship (if other than patient): _____ Patient e-mail: _____

TO ENROLL IN THE GSK CO-PAY ASSISTANCE PROGRAM, COMPLETE SECTIONS A, B, C, AND G OF THIS FORM.

GSK Co-Pay Assistance Program is a patient assistance program sponsored by GlaxoSmithKline that helps eligible patients pay insurance copayments for certain GSK products. 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 contacted after their information is processed. 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

Number of people, including the Applicant, who 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 1 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 a plan purchased on an individual basis? Yes No

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, the 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)

← Sign Here

REMEMBER TO:

- **Complete the form as directed.** 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 a copy of Page 1 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.

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



The CARES by GSK logo is a trademark of GlaxoSmithKline.