GSK Patient Assistance Program
PO Box 220590, Charlotte, NC 28222-0590
Phone: 1-866-728-4368, Fax: 1-855-474-3063
Monday – Friday 8am-8pm ET

GSK Patient Assistance Program Vaccine Application

- ☐ **Prior to enrolling patients, prescribers must register in the program by going to www.gskpatientassistanceprogramportal.com**
- ☐ **Complete and sign this form. A signature is needed from the patient and the healthcare prescriber.**
- ☐ **GSK Patient Assistance Program (GSK PAP) is no longer able to offer single dose vials for GSK PAP replenishment.**
- ☐ **A site must accumulate a total of 10 approved doses of product within 12 months before replenishment will be sent to the site. Doses approved for all practicing physicians at a unique site address will count towards the accumulation.**
- ☐ **Failure to accumulate 10 approved doses of a product within 12 months will result in replenishment being forfeited.**
- ☐ **The maximum amount of product available from GSK PAP is limited to 200 doses per product per year (20 shipments of 10 vaccines) per unique site.**
- ☐ **This is a replenishment program. Patients should be vaccinated with previously purchased GSK vaccine upon approval into GSK PAP.**
- ☐ **By signing this form, the provider accepts the terms and conditions of the program and understands the risks if an increment of 10 approved doses is not reached within 12 months.**

Section 1: Vaccine Requested (Required)

☐ 58160-842-52 – Boostrix
Tetanus Toxoid, Reduced Diphtheria Toxid & Accellular Pertussis Vaccine, Absorbed

☐ 58160-821-52 – Engerix-B
Hepatitis B Vaccine, Recombinant

☐ 58160-823-11 - Shingrix
Herpes Zoster Recombinant Subunit Vaccine

Section 2: Prescriber Information (Required)

Prescriber Name: _____

Facility Name: _____

Shipping Address: _____

City:_____State:_____Zip:_____State License Number: _____

Phone: (___)_____-_____Fax: (____)_____-_____Preferred Delivery Day: Tues ☐ Wed ☐ Thu ☐ Fri ☐

Section 3: PAP Replenishment Guidelines and Prescriber Certification (Required) NEW REQUIRMENTS PLEASE READ

PAP REPLISHMENT GUIDELINES: GSK Patient Assistance Program (GSK PAP) is no longer able to offer single dose vials for PAP replenishment. A site must accumulate a total of 10 doses within 12 months in order to be eligible for replenishment through the program. Doses approved for all practicing physicians at a unique site address will count towards the accumulation. Furthermore, the total amount of replenishment product received through the GSK PAP will be capped at 200 doses per product per year (20 shipments of 10 vaccines) per unique site.

PRESCRIBER CERTIFICATION: By enrolling my patient into GSK PAP, I understand that if my site does not dispense 10 doses for approved PAP patients within 12 months that I will not be eligible for replenishment. My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive, and administer the requested medication(s) listed on this program enrollment form, shipped from the GSK PAP. I attest that the vaccine requested is indicated medically for the identified patient. I certify to the best of my knowledge, that the information on this application is correct and complete. I attest that the product I am requesting is a replacement of a previously purchased GSK vaccine used on an approved PAP qualified patient. I also understand that eligibility under the program is subject to GSK's discretion and GSK reserves the right to modify or terminate the GSK PAP at any time. I represent that I have obtained all necessary authorizations from my patient to allow me to release information to GSK and its contracted third parties. My signature confirms that the vaccine product has been or will be provided at no cost to the patient listed on this form and I understand that I am not eligible to seek reimbursement from any source for any medication provided by the GSK PAP for this patient. I understand that I will not receive reimbursement from GSK for the administration of this vaccine for this patient and further agree that I will not seek reimbursement for administration of the vaccine from any public payer for this patient.

Prescriber Signature:_____Date: _____
(Original signature required. Stamped signature not accepted.)

New PAP replenishment guidelines. Please read carefully!

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Section 4: Applicant Information (Required)

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

Mailing Address:_____City:_____State:_____Zip: _____

Home Phone Number: (____)_____-_____ Cell Phone Number: (____)_____-_____ Birth Date:_____/_____/_____

Email: _____

Medicare Beneficiary Identifier (MBI) - Medicare Part D patients only:_____

Household size:_____ Current annual household income: $_____

For patients with no income: ☐ By checking this box, I attest that to the best of my knowledge the applicant has no income.

Does the patient 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 ☐ _____

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. For additional information about how GSK handles your information, please see our privacy notice at https://privacy.gsk.com/en-us.

Patient Signature: _____ Date: _____

(Original signature required. Stamped signature not accepted.)

To prevent processing delays, please fill out the form in its entirety.