

Support for your patients



GlaxoSmithKline is committed to helping patients gain access to our medications. We understand that the healthcare insurance system is often complex and confusing. The *CARES by GSK* program provides a variety of services to help patients and healthcare providers navigate this system.

Benefits to enrolled patients include:

- Insurance coverage and benefits verification
- Enhanced delivery of medications
- Research into alternative funding options
- Patient connection to assistance programs



To enroll your patient today, complete the enclosed enrollment form or call 1-888-663-4752. Live agents are available 8:30 AM to 8:00 PM Eastern Time. You can also call and leave a message 24 hours a day.


Instructions on Completing Enrollment Form for Reimbursement Support

Enroll your patients by completing Sections A to E. Section F, Patient Support Program is not yet available. Enrollment is not mandatory.

To enroll your patient today, complete the enclosed enrollment form or call 1-888-663-4752. Live agents are available 8:30 AM to 8:00 PM Eastern Time. You can also call and leave a message 24 hours a day.

Page 1 of 2

ENTER PRODUCT NAME _____

Program Enrollment Form Phone: (888) 663-4752 Fax: (866) 272-9439  GlaxoSmithKline

Section A: Patient Information

Patient Name: _____
 Address: _____
 (Work) _____ (Cell) _____ Alternate Contact: _____
 Physician Information
 Physician Name: _____ Site Name: _____ Site Contact Name: _____
 Address: _____ Phone: _____ Fax: _____
 Tax ID #: _____ Payer Specific ID #: _____ NPI #: _____

Section B: 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 is "protected health information." See page 2 of 2 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: _____ Date: _____ **Sign Here**

Section C: Clinical Information, Insurance, and Financial Information

Diagnosis & ICD-9 Code: _____ Previous Therapy: _____
 Primary Rx Insurer: _____ Phone: _____
 Policy ID #: _____ Group #: _____
 Subscriber Name: _____ Date of Birth: _____
 Secondary Rx Insurer: _____ Phone: _____
 Policy ID #: _____ Group #: _____
 Subscriber Name: _____ Date of Birth: _____

Section D: Prescription Information

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

Section E: 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 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): _____ Date: _____ **Sign Here**

Section F: Prescription Fulfillment

Specialty Pharmacy

Product is available from multiple authorized specialty pharmacies through the CARES by GSK program. Please contact 1-888-663-4752 for a complete list of authorized specialty pharmacies. Unless patient requests otherwise, the prescription will be directed to the authorized specialty pharmacy that provides the lowest cost-sharing for patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected based on uniformly applied selection criteria.

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

Please direct prescription to the following authorized specialty pharmacy offering this specialty pharmacy offers the lowest cost-sharing option for 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 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: _____

Please Complete Page 2 of 2

Page 2 of 2

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 only use or disclose information it receives 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 have the right to revoke this authorization at any time by calling 1-888-663-4752 and mailing a signed written revocation to PO Box 220725, Charlotte, NC 28222-2275, 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. To the extent that action has been taken in reliance on this authorization, this means that, after you revoke this authorization, the 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 Lash Group and any other companies that GSK uses to administer CARES by GSK, to do the following:

- 1) Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information 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 to my treating physician, healthcare professional, or pharmacist information I have provided to CARES by GSK when 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 Lash Group;
- 4) Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, patient assistance programs (eg, GSK's Commitment to Access Program), on my behalf in order 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): _____ Patient signature: _____ Date: _____ **Sign Here**

Relationship if other than patient: _____

ENROLLMENT IN CARES BY GSK PATIENT ADHERENCE PROGRAM ("adherence program")


The patient, or the patient's authorized representative, MUST sign this form in order to receive GSK's patient adherence program ("adherence program") services. The adherence program is designed to provide you with product information and help you adhere to your medication. 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 Lash Group and any other companies that GSK uses to administer the adherence program, to do the following:

- 1) Contact me via telephone (including voicemail) with information about this adherence program and provide me with product information about product and information about adherence 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 adherence program for the purpose of providing me with information, contacting me, and otherwise administering the adherence 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 adherence 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 Lash Group and any other companies that GSK uses to administer the adherence 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 adherence program.

Patient name (print): _____ Patient signature: _____ Date: _____ **Sign Here**

Relationship if other than patient: _____

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- SECTION A:** Provide patient's and physician's full contact information. Supply physician's tax ID number to verify the patient's insurance benefits. Provide physician's state license and DEA numbers for shipping medication
- SECTION B:** Have the patient sign the Patient Consent/Authorization section for medication to be shipped
- SECTION C:** Fill out the Clinical Information, Insurance Information, and Financial Information
- SECTION D:** Fill out the prescription information completely and be sure to have the prescribing physician sign and date to ensure timely dispensing of medication
- SECTION E:** Have the patient sign the enrollment form to receive reimbursement services
- SECTION F:** Enrollment into the Patient Support Program is not yet available



To enroll your patient today, complete the enclosed enrollment form or call 1-888-663-4752. Live agents are available 8:30 AM to 8:00 PM Eastern Time. You can also call and leave a message 24 hours a day.

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ENTER PRODUCT NAME

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Phone: (888) 663-4752 Fax: (866) 272-9439



Patient Information

A

Patient Name: _____ Date of Birth: ____/____/____
Address: _____ Phone: (Home) _____
(Work) _____ (Cell) _____ Alternate Contact): _____
(name/phone)

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, prescription/medical information, is "protected health information." See page 2 of 2 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.

B

Signature of Patient or Patient Representative: _____ Sign Here
Name (print) _____ Date: ____/____/____
(If signed by representative, explain authority to act for the Patient.) _____

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

C

Insurance

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

Patient Financial Information (Complete only if you want help to determine eligibility for other sources of coverage or assistance)

Current household income: _____ Number of family members who rely on that income: _____ Out of Pocket Medical Expenses: _____

Prescription Information

D

Medication: _____ 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 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

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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: _____

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I also understand that I have the right to revoke this authorization at any time by calling 1-888-663-4752 and mailing a signed written statement of my revocation to PO Box 220725, Charlotte, NC 28222-2275, 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.

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

- 1) Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information 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 to my treating physician, healthcare professional, or pharmacist information I have provided to CARES by GSK when 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 Lash Group;
- 4) Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, patient assistance programs (eg, GSK's Commitment to Access Program), on my behalf in order 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) _____ Patient signature _____ Date _____

← Sign Here

Relationship if other than patient: _____

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

- 1) Contact me via telephone (including voicemail) with information about this adherence program, including providing information about product and information about adherence 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 adherence 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 adherence 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 Lash Group and any other companies that GSK uses to administer the adherence 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 adherence program.

Patient name (print) _____ Patient signature _____ Date _____

← Sign Here

Relationship if other than patient: _____



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