PO Box 52046 • Phoenix, AZ 85072-2046
Phone Number: 1-866-518-HELP (4357)
Fax Number: 1-866-518-3994
www.GSK-Access.com

GSK Access is a program sponsored by GlaxoSmithKline that provides GlaxoSmithKline prescription medicines at no cost to Medicare Part D Prescription Drug Plan enrollees who meet the eligibility requirements. Eligibility is based on annual household income and proof that the applicant has spent $600 or more for prescription medicines since January 1, 2008. A completed application along with income documentation, proof of prescription expenses and a copy of the Medicare Part D Plan ID card must be sent to GSK Access for processing. Applicants will be notified if they qualify for the program and, if approved, a GSK Access Card will be mailed to the applicant that may be used at any retail pharmacy to pick up GlaxoSmithKline medicines at no cost. Drugs received from this program do not count toward True Out-of-Pocket Spending (TrOOP).

YOU CAN APPLY IF:

- **You are enrolled in a Medicare Part D Prescription Drug Plan;**
- **You have spent at least $600 on prescription medications since January 1, 2008;**
- **You reside in one of the 50 states or the District of Columbia; and**
- **Your total household annual income is equal to or less than the amounts shown below.**

GSK Access Income Guidelines

Household Size	Annual Household Income*
1	less than $26,351
2	less than $35,301
3	less than $44,251
4	less than $53,201

Annual household income amounts for Alaska and Hawaii are higher.

Instructions on how to complete the application are located on page 2.

Mail or fax the completed application form along with all documentation to:

GSK Access
PO Box 52046
Phoenix, AZ 85072-2046
Fax Number: 1-866-518-3994

If you have any questions, please call GSK Access toll-free at 1-866-518-HELP (4357) Monday through Friday 8:00 am to 8:00 pm Eastern Time, and a customer service representative will be happy to talk to you.

GSK Access Application Instructions

- Be sure to print the applicant's name and date of birth on each page submitted.

SECTION 1 *Applicant Information*

- Fill in each box or line with the applicant's information.

SECTION 2 *Medicare Part D Prescription Drug Plan information*

- The applicant must be enrolled in a Medicare Part D plan to be eligible for GSK Access.

Required Documentation

✔ Enclose a copy of the applicant's Medicare Part D Plan card. Do not send the original card.

SECTION 3 *Medicare Part D Prescription Drug Expenses*

- Fill in the total amount the applicant has spent on prescription medicines since January 1, 2008.

Required Documentation

✔ If the applicant's prescription expenses total $600 or more, provide the most recent explanation of benefits from the Medicare Part D prescription drug plan or printout from the pharmacy that lists the 2008 prescription expenses. These expenses must be for the applicant only and expenses for family members are not included. Monthly premiums also do not count towards the $600 total. Copays, deductables and direct costs of prescription medications should total $600 or more. This expenditure can be for any prescription medicines, not just GSK products.

If the applicant has not spent $600 for prescription expenses yet, please wait to apply to GSK Access.

SECTION 4 *Household Information*

- Fill in the number of people who are in the applicant's household. Provide the number of people, including the applicant, who contribute to or are dependent on the applicant's household income.
- Fill in the total annual household income. List gross annual income for all people who contribute to or are dependent on the applicant's household income.

Required Documentation

✔ If the answer to the question on filing income tax is "Yes," please provide a copy of page one of the most recently filed tax return. (1040, 1040A or 1040EZ)

✔ If the answer to the question on filing income tax is "No," please provide a copy of the most recent Social Security Benefit Statement for each member of the applicant's household.

✔ If the applicant's income is below 135% of the Federal Poverty Level (see below), the applicant is required to apply for the Social Security Administration Low Income Subsidy prior to applying for GSK Access. If the applicant has applied for Low Income Subsidy and did not receive full assistance, a copy of the response notice from the Social Security Administration must be submitted to GSK Access. If the applicant qualifies for full Low Income Subsidy assistance, all medicines will be paid for under this benefit and assistance through GSK Access is not needed. For questions regarding this benefit, call the Social Security Administration at 1-800-772-1213. Applicants may apply online for the Low Income Subsidy through the Social Security Administration website at http://ssa.gov/prescriptionhelp.

Low Income Subsidy Income Guidelines

Household Size	Annual Household Income*
1	less than $13,784
2	less than $18,482
3	less than $23,180
4	less than $27,878

Annual Household Income amounts for Alaska and Hawaii are higher.

Applicant Signature:

- The applicant must sign the "Patient Authorization to Release and Disclose Medical Information."

Reset Form

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GSK Access 2008 Application

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See Instructions on page 2

Tear Off and MAIL or FAX pages 3 and 4.

SECTION 1 *Applicant Information*

Applicant Name (First):_____

(Last):_____(M.I.):_____

Street Address:_____

City:_____

State:_____ZIP Code:_____

Phone number with area code: (_____) _____ - _____

Email Address (if any):_____Race *(Optional)*:_____

Social Security #: ☐☐☐–☐☐–☐☐☐☐

Birth Date: *MM* _____ / *DD* _____ / *YYYY* _____

Gender: M ❒ F ❒

SECTION 2 *Medicare Part D Prescription Drug Plan Information*

See Instructions for Required Documentation on page 2.

Is the applicant enrolled in a Medicare Part D Prescription Drug Plan? YES ❒ NO ❒

The applicant must be enrolled in a Medicare Part D Plan to be eligible for GSK Access.

SECTION 3 *Medicare Part D Prescription Drug Expenses*

See Instructions for Required Documentation on page 2.

How much has the applicant spent on prescription medicines since January 1, 2008? $_____

SECTION 4 *Household Information*

See Instructions for Required Documentation on page 2. Low Income Subsidy response notice may be required.

Household Size: _____

Provide the number of people, including the applicant, who contribute to or are dependent on the applicant's household income.

Total Annual Household Income: $_____

Provide the income for all people, including the applicant, who contribute to or are dependent on the applicant's household income.

Did the applicant file an income tax form or was the applicant listed as a dependent on someone else's income tax form for the most recently filed tax year? YES ❒ NO ❒

Applicant Signature: Sign the "Patient Authorization to Release and Disclose Medical Information" on the back of this page.

Patient Authorization to Release and Disclose Medical Information

By my signature I authorize GlaxoSmithKline, as well as McKesson Specialty Arizona Inc. (MSAZ) and any other companies that GlaxoSmithKline uses to administer GSK Access (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 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 GlaxoSmithKline 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. 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, MSAZ or any company that GlaxoSmithKline uses to run 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 Program 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.

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 Medical Information. I also understand that I have the right to revoke this authorization at any time by calling 1-866-518-HELP (4357) 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 currently enrolled in a Medicare plan that includes Part D drug coverage. 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*_____

Did you remember to:

- ❑ **Fill out** the application completely.
- ❑ **Sign** the application.
- ❑ **Enclose a copy** of the Medicare Part D Prescription Plan ID card.
- ❑ **Provide proof** of $600 in 2008 prescription expenses from the most recent PDP Plan Statement or a statement from the local pharmacy.
- ❑ **Provide proof** of income, either a tax return or Social Security statement.
- ❑ **If applicable, provide a copy** of the Low Income Subsidy response notice.
- ❑ **Be sure to print the applicant's name and date of birth** on each page submitted.

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