GSK VACCINES ACCESS PROGRAM

GlaxoSmithKline

www.GSK-VAP.com
Phone: 1-877-VACC-911 (877-822-2911)
Fax: 1-877-822-1555

GSK Vaccines Access Program is a patient assistance program sponsored by GlaxoSmithKline that provides GlaxoSmithKline vaccines to adult applicants who meet eligibility requirements. Prior to enrolling patients, the prescriber must register in the program at www.GSK-VAP.com. For patient enrollment, fax the completed application along with income documentation to 1-877-822-1555. Once approved, the applicant will be eligible to receive appropriate vaccines for up to one year. Applicants must re-apply annually. Subsequent doses for enrolled patients require a completed Dosage Authorization Form to be faxed and approved. Additional information about eligibility requirements, program enrollment, and how to complete this form can be obtained at www.GSK-VAP.com or by calling 1-877-VACC-911 (877-822-2911) M-F, 9:00 am – 7:00 pm ET.

SECTION 1: APPLICANT INFORMATION

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

Mailing Address: _____

City: _____ State: _____ Zip code: _____ Phone Number: (_____) _____ - _____

Birth Date: ___ / ___ / _____ *MM/DD/YYYY* Gender: ☐ M ☐ F Race (Optional): _____

Number of people, including the Applicant, who contribute to or are dependent on the household income? _____

Total Gross Monthly Income _____ **OR** Total 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 one of the tax form. If no 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.

SECTION 2: PRESCRIPTION COVERAGE

Do you have third party coverage for vaccines from either a private or government payer? Yes ☐ No ☐

SECTION 3: DOSE RELEASE: TO BE COMPLETED IF DOSED TODAY. FOR SUBSEQUENT DOSES PLEASE USE THE DOSAGE AUTHORIZATION FORM.

58160-815-32 -Twinrix®- ☐ Dose 1 ☐ Dose 2 ☐ Dose 3
Hepatitis A Inactivated & Hepatitis B (Recombinant)Vaccine

58160-815-32 - Twinrix® Accelerated Dosing- ☐ Dose 1 ☐ Dose 2 ☐ Dose 3 ☐ Dose 4
Hepatitis A Inactivated & Hepatitis B (Recombinant)Vaccine

58160-830-32 - Cervarix ®- ☐ Dose 1 ☐ Dose 2 ☐ Dose 3
Human Papillomavirus Bivalent (Types 16 and 18) Vaccine, Recombinant

58160-842-32 - Boostrix® - ☐ Dose 1
Tetanus Toxoid, Reduced Diphtheria Toxoid & Acellular Pertussis Vaccine, Adsorbed

58160-826-32 - Havrix ®- ☐ Dose 1 ☐ Dose 2
Hepatitis A Vaccine

58160-821-32 - Engerix-B®- ☐ Dose 1 ☐ Dose 2 ☐ Dose 3
Hepatitis B Vaccine, Recombinant

REMEMBER: An incomplete application will delay processing. Call 1- 877-822-2911 with any questions about how to complete this form.

- ☐ **Complete and sign the form**.
- ☐ **Applicants:** must be ages 19 or older, **Cervarix applicants**: must be female, ages 19-25 years
- ☐ **Fax the following:**
  - Completed and signed application.
  - Proof of income: See Section 1 above for examples of income documentation requirements
- ☐ **Obtain approval** before administration of the vaccine

Required Signatures on Page 2

SECTION 4: PRESCRIBER INFORMATION

Prescriber registration ID# _____

Prescriber must register for patient program enrollment on-line at www.GSK-VAP.com. If there are questions related to the registration process, please call at 1-877-VACC-911 (1-877-822-2911).

Prescriber name: _____ SLN# :_____ Expiration date: _____

SHIPPING ADDRESS FOR VACCINE REPLENISHMENT

Clinic name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip code: _____

Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____

Preferred delivery day: Tue Wed Thu Fri (circle one)

SECTION 5: PATIENT AUTHORIZATION AND CERTIFICATION

I authorize my health care providers to provide the GSK Vaccines Access Program and its administrators information including my name, address, prescription drug records and any other personally identifying information related to my application for vaccines from the GSK Vaccine Access program. I understand that the information I provide will be used to determine my eligibility for the GSK Vaccines Access program, to administer the program or to comply with any requests for disclosures required by law. This authorization will extend for as long as I participate in the GSK Vaccines Access program and for a period of three years thereafter.

I understand that once medical information has been provided to the GSK Vaccines Access program, my medical information may no longer be protected by federal privacy laws and may be further disclosed. I may revoke this authorization at any time by providing written notice to GSK Vaccines Access program at the address set forth above. My revocation will become effective on the date my written notice is received and processed by the GSK Vaccines Access Program at P.O. Box 18428, Louisville, KY, 40261. Once I revoke my authorization I will no longer be qualified to receive medication assistance from the GSK Vaccines Access Program.

I understand that eligibility under the GSK Vaccines Access Program is subject to GlaxoSmithKline's discretion and GlaxoSmithKline reserves the right to modify or terminate the GSK Vaccines Access Program at any time.

I certify that I am not eligible to receive reimbursement for this vaccine from any insurer or government program, including Medicare Part D. 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: _____

SECTION 6: PRESCRIBER CERTIFICATION:

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 GSK Vaccines Access program. 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 Dosage Authorization Request Form is correct and complete. I attest that the product I receive is a replacement of a previously purchased GlaxoSmithKline vaccine. I also understand that eligibility under the program is subject to GlaxoSmithKline's discretion and GlaxoSmithKline reserves the right to modify or terminate the GSK Vaccines Access program at any time. I represent that I have obtained all necessary authorizations from my patient to allow me to release information to GlaxoSmithKline and its contracted third parties.

My signature confirms that the vaccine product 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 Vaccines Access Program. I understand that I will not receive reimbursement from GlaxoSmithKline for the administration of this vaccine and further agree that I will not seek reimbursement for administration of the vaccine from any public payer.

- **Prescriber Signature:** _____ **Date:** _____