



Commitment to Access
 PO Box 29038
 Phoenix, AZ 85038-9038
 1.8ONCOLOGY1 (1.866.265.6491)
www.CommitmentToAccess.com



PATIENT ID #: _____

FOR USE BY ADVOCATE - PHONE CALL REQUIRED

Commitment to Access is a patient assistance program sponsored by GlaxoSmithKline that provides GlaxoSmithKline oncology and specialty pharmacy medicines to applicants who meet eligibility requirements. Eligibility is based on household size and insurance status. This application is for prescribers and health care advocates registered with Commitment to Access to use for phone enrollment of patients. Call 1.8ONCOLOGY1 or visit www.CommitmentToAccess.com for additional information.

APPLICANT INFORMATION

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

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____ Phone Number: (_____) _____ - _____

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

Social Security #: - -
 Birth Date: MM / DD / YYYY Gender: M F

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 one of the tax form (acceptable tax forms are 1040, 1040A or 1040EZ only). 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

1. Is the patient eligible for any state or federal prescription drug program such as Medicaid or Puerto Rico's Government Healthcare Plan Reforma? Yes No
2. Does the applicant have any private prescription drug coverage? Yes No
If yes to either of the above, please indicate why assistance is needed:
 Medicine not on plan drug list Pre-existing condition Over plan coverage limit
 Other (please explain) _____
3. Is the applicant enrolled in a Medicare Part D prescription drug plan? Yes No

SHIPPING ADDRESS Only complete this section if medicine is being shipped somewhere other than the Mailing Address above.

Addressee or Business Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Specify addressee's relationship to the applicant: Self Advocate (must complete Advocate Information below)
 Other (specify relationship) _____

ADVOCATE INFORMATION

Advocate ID Number: _____ (Register at www.CommitmentToAccess.com or by calling 1.8ONCOLOGY1)

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

Facility Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

ALLERGY AND HEALTH INFORMATION

List any known drug allergies and health conditions: _____



APPLICANT 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 Commitment to 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 1.8ONCOLOGY1 (1.866.265.6491) 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. There is a copayment for each prescription filled at a retail pharmacy. If my advocate charges a fee for enrollment or refills of my medicine, this money is not paid to GlaxoSmithKline.

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)

ADVOCATE CERTIFICATION

By my signature, I certify to the best of my knowledge, the information on this application is correct and complete. I have no knowledge of any intent to sell, barter or give this product to any person other than the Applicant for whom it has been prescribed. To the best of my knowledge, the Applicant has no medical/prescription insurance benefits for the indicated pharmaceutical(s), including Medicaid or other public programs other than as indicated, and the Applicant has insufficient financial resources to pay for the prescribed therapy.

Advocate Signature (Original signature required. Stamped signature not accepted.)

Date

REMEMBER TO:

- Complete the entire form.** An incomplete application will delay processing. Call 1.8ONCOLOGY1 (1.866.265.6491) or visit www.CommitmentToAccess.com with any questions about how to complete this form.
- Call to enroll the patient.**
- Mail the following:**
 - ◆ **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 one of the tax form (acceptable tax forms are 1040, 1040A or 1040EZ only). 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.
 - ◆ **If the patient is enrolled in a Medicare Part D plan, proof of \$600 spend and copy of Medicare Part D card.**
- Fax signed original prescription(s) for GlaxoSmithKline medication written for a 30-day supply with refills if medically appropriate.**
- Keep a copy of the application and all documents for your records.** Please print applicant's name and date of birth on all documents.