ADVOCATES MUST CALL WITH A COMPLETED AND SIGNED FORM TO ENROLL EACH PATIENT. DO NOT MAIL UNTIL DIRECTED.

BRIDGES to ACCESS

PO Box 29038 • Phoenix, AZ 85038-9038
1-866-PATIENT(728-4368)
www.BridgesToAccess.com

GSK Product Requested:	ICD-9 Code for Primary Diagnosis:
1._____	_____ _____ _____ . _____ _____
2._____	_____ _____ _____ . _____ _____

GlaxoSmithKline

PATIENT ID #:

SECTION 1 - PATIENT INFORMATION

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

Street Address:_____

City:_____ State:_____ ZIP Code:_____ Phone #: (_____) _____

Drug Shipping Address (if different from above) C/O or Business Name: _____

Street Address:_____ City:_____ State:_____

ZIP Code:_____ Phone #: (_____) _____ Email Address: _____

Social Security #: ☐☐☐ - ☐☐ - ☐☐☐☐ Birth Date: MM _____ / DD _____ / YYYY _____ Gender: M ❑ F ❑ U.S. Resident: YES ❑ NO ❑

Legally Disabled: YES ❑ NO ❑
If yes, has patient been legally disabled more than two years? YES ❑ NO ❑

Veteran: YES ❑ NO ❑

Race (Optional): _____

HOUSEHOLD SIZE & INCOME: List gross monthly income by income type for all people who contribute to or are dependent on patient's household income.

HOUSEHOLD SIZE: _____ (Include number of people, including patient, who contribute to or are dependent on patient's household income.)

Salary/Wages: _____ Social Security Disability: _____ Veterans Benefits:_____

Social Security Retirement:_____ Unemployment:_____ Pension/Retirement: _____

Supplemental Security Income:_____ Alimony/Child Support:_____ Other: _____ **TOTAL MONTHLY INCOME $:** _____

INSURANCE INFORMATION: Indicate if patient has prescription drug benefits through any insurer/payer/program and why the prescribed GSK product is not covered.

Medicare – Is the patient eligible for Medicare? YES ❑ NO ❑
If yes, has the patient enrolled in any Medicare plan that includes Part D drug coverage? YES ❑ NO ❑

Does patient have prescription drug benefits through any of the following insurers/payers/programs? (Y = Yes, N = No, P = Pending or wait listed)		If "Y", circle the appropriate letter for each insurer to indicate why the GSK product is not covered. (A = Capitation limit; B = GSK product not on formulary; C = Plan covers generic drugs only; O = Other - *list reason*)			
Medicaid	Y ☐ N ☐ P ☐	A	B	C	O : _____
Private Insurance	Y ☐ N ☐ P ☐	A	B	C	O : _____
AIDS Drug Assistance Program	Y ☐ N ☐ P ☐	A	B	C	O : _____
State Children's Insurance Program	Y ☐ N ☐ P ☐	A	B	C	O : _____
Other State Drug Assistance Program	Y ☐ N ☐ P ☐	A	B	C	O : _____
Veterans Affairs Drug Benefits	Y ☐ N ☐ P ☐	A	B	C	O : _____
Other - List Name: _____	Y ☐ N ☐ P ☐	A	B	C	O : _____

SECTION 2 - PRESCRIBER INFORMATION

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

Street Address:_____ City:_____

State:_____ ZIP Code:_____ Phone #: (_____) _____ Fax #: (_____) _____

DEA #:_____ Email Address: _____

SECTION 3 - ADVOCATE INFORMATION

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

Facility Name:_____ Street Address:_____

City:_____ State: _____ ZIP Code:_____

Phone #: (_____) _____ Fax #: (_____) _____ Email Address: _____

SECTION 4 - SIGNATURES

Patient (or authorized representative), prescriber, and advocate must read and sign the Certification and Consent to Release and Disclose Medical Information on the back of this form. **PATIENT SIGNATURE IS REQUIRED PRIOR TO PHONE ENROLLMENT.**

ADVOCATE: FOR YOUR PATIENT TO OBTAIN DRUG IMMEDIATELY, COMPLETE THE PATIENT VOUCHER BELOW AND GIVE IT TO PATIENT **AFTER** THE ENROLLMENT CALL.

GSKCS 051345D1 12/05

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Tear on the dotted line

BRIDGES to ACCESS

1-866-728-4368
www.BridgesToAccess.com

PATIENT VOUCHER

Patient Name: _____

Advocate Name: _____

Advocate Phone Number: (_____) _____

This Patient Voucher serves two purposes: [1] it is your program identification, and [2] it will help your pharmacy process your prescription claim correctly.

HOW TO FILL YOUR INITIAL PRESCRIPTION THROUGH BRIDGES TO ACCESS:

- After your advocate successfully enrolls you by phone, take this voucher and your GSK prescription(s) to a local retail pharmacy.
- You may obtain up to a 60-day supply per drug for a minimum copay per fill.
- If necessary, refills for most medicines are available through our mail order pharmacy. Your advocate can tell you how to obtain refills.
- Do not attempt to obtain refills at your local pharmacy after 60 days unless directed to by your advocate.
- Contact your advocate if you have any questions.

PATIENT ID#:

PHARMACY PROCESSING INFORMATION
Processor - McK
RxBIN - 610500
RxGRP - H1160001

Pharmacy Questions - Call 1-866-728-4368 between 8:00am - 8:00pm Eastern Time

THIS VOUCHER BECOMES VALID FOR USE AT A RETAIL PHARMACY AFTER PHONE ENROLLMENT IS COMPLETED.

GlaxoSmithKline