# GSK Co-pay Program Enrollment Form

The **GSK Co-pay Program** may provide assistance for **out-of-pocket costs** for eligible patients.

**1** **To begin, confirm you meet the following eligibility criteria for the program:**

- ☑ You have been treated with the GSK monoclonal antibody for COVID-19
- ☑ You have paid the out-of-pocket costs for the drug and/or for its administration
- ☑ You do not have health insurance through Medicare, Medicaid, or a similar state or federal program

**If you meet all of the criteria above, proceed to step 2.**

**2** **Next, complete Sections 1 and 2 of the Enrollment Form on page 2 to request co-pay assistance. Note that completing the enrollment form does not guarantee eligibility for the program.**

- ☑ Complete Sections 1 and 2 of the form:
  1. Patient information
  2. Insurance information

**Must be submitted within 90 days from the Explanation(s) of Benefits (EOB) issue date**

**3** **Read the Patient Authorization and Release to Collect, Use, and Disclose Health Information on page 3, then sign and date the form on page 2.**

**4** **Mail or fax the completed form along with the required receipt(s), Explanation(s) of Benefits, and a copy of the front and back of your insurance card(s) to:**

Address: GSK Co-pay Program
PO Box 1326
Morristown, NJ 07962

Fax: 1-866-918-2919

Required documentation must be submitted before assistance can be provided to eligible patients.

Checks will be sent to eligible patients at the address provided on the enrollment form within 7-10 business days.

For any additional questions regarding the Enrollment Form or the co-pay assistance process, please call the **GSK COVID Contact Center at 1-866-GSK-COVID (866-475-2684)**, 9 AM - 6 PM ET, Mon-Fri (excluding holidays).

# GSK Co-pay Program Enrollment Form

**To seek assistance through the program, complete all fields below and return this form along with the required receipt(s), Explanation(s) of Benefits from your insurance company(ies), and a copy of the front and back of your insurance card(s).**

## Section 1: Patient Information

| First name: | Last name: | Gender: M / F (please circle) |
|---|---|---|
| Mailing address (street address or PO Box): | | |
| City: | State: | Zip code: |
| Date of birth: | Phone #: | |
| Received GSK monoclonal antibody for COVID-19: Y / N (please circle) | Date of service: | |
| Receipt(s) attached:<br>☐ For the GSK monoclonal antibody for COVID-19<br>☐ For administration of the GSK monoclonal antibody for COVID-19 | ☐ Explanation(s) of Benefits attached | |
| Patient caregiver full name (parent, guardian, etc): | | |

## Section 2: Insurance Information

Indicate insurance type:

☐ Private commercial ☐ Medicare/Medicaid ☐ TRICARE ☐ No insurance

**Please provide copies of the front and back of all medical and prescription insurance cards.**

| Primary insurance provider: | Group #: | |
|---|---|---|
| Primary insurance phone #: | Subscriber ID #: | |
| Cardholder name (if not the patient): | Cardholder date of birth: | Rx BIN # (under pharmacy benefit): |
| Secondary insurance provider: | Group #: | |
| Secondary insurance phone #: | Subscriber ID #: | |
| Cardholder name (if not the patient): | Cardholder date of birth: | Rx BIN # (under pharmacy benefit): |

# Patient Signature

I have read and agree with the PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION on page 3.

Signature of patient or authorized representative*: _____ Date: _____

*Indicate relationship to patient: _____

**Once the form is completed, please mail or fax it with required documentation to:**

Address: GSK Co-pay Program
PO Box 1326
Morristown, NJ 07962

Fax: 1-866-918-2919


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## PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

By signing this form, I agree to allow my doctors and health insurers (collectively "Healthcare Providers") to use and disclose my health information to GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing GSK Co-pay Program services and may engage in the following activities:

1. Communicating with my Healthcare Providers about my GSK COVID-19 monoclonal antibody prescription
2. Investigating my insurance coverage, or reviewing my eligibility for the GSK Co-pay Program
3. Disclosing my information to third parties if required by law

By signing this authorization, I acknowledge my understanding that:

- My Healthcare Providers will not and may not condition my treatment, payment for treatment, eligibility for or enrollment in benefits on whether I sign this Patient Authorization.
- Once information about me is released to GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent GSK from further disclosing my information. However, I understand that GSK has agreed to use or disclose information received only for the purposes described in this authorization or as required by law.
- This authorization will remain in effect for one year after I sign it (unless a shorter period is required by state law) or for as long as I participate in the GSK Co-pay Program, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to PO Box 1326, Morristown, NJ 02962, but that such a revocation would end my eligibility to participate in the GSK Co-pay Program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date written revocation is received but will not apply to the extent that they have already taken action in reliance on this authorization. After this authorization is revoked, I understand that information provided to GSK prior to the revocation may be disclosed within GSK to maintain records of my participation.
- The patient, or the patient's authorized representative, MUST sign this form to receive GSK Co-pay Program services. If an authorized representative signs for the patient, please indicate relationship to the patient.