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Patient Eligibility

Patients who meet the following criteria may be eligible for GSK Vaccines Access Program:

- The patient has no health insurance for vaccines,
- The patient is an adult, age 19 or older, or a female between 19 and 25 for Cervarix,
- The patient lives in one of the 50 states or the District of Columbia, and
- The patient has an annual household income less than or equal to 250% of the federal poverty level, adjusted by household size.

Income limits

	Maximum Monthly Gross Income		
Household Size	48 States and D.C.	Alaska	Hawaii
1	$2,393.75	$2,989.58	$2,756.25
2	$3,231.25	$4,037.50	$3,718.75
3	$4,068.75	$5,085.42	$4,681.25
4	$4,906.25	$6,133.33	$5,643.75
For each additional person, add	$837.50	$1,047.92	$962.50

Calculate your monthly income limit if you have more than 4 people in your household

Select a number

Proof of Household Income

Send in proof of current income and other requested documents along with the completed and signed application and a prescription with refills if medically appropriate for mail order refills.

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 tax 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. Please provide copies, not originals, of pay stubs, unemployment stubs, Social Security statements, pension statements, and any other sources of income. The following are examples of acceptable proof of income:

- **Income tax form:**
  - A copy of page 1 of the most recently filed 1040, 1040A or 1040EZ tax return
- **Salary/wages:**
  - One month consecutive salary/income documentation
  - A copy of a pay stub with year-to-date income
  - Letter indicating salary/wages on company letterhead
  - Notarized statement from employer
  - Bank statement showing salaries and wages deposited by employer

- **Self employment income:**
  - 1099 form including Schedule C from the most recent tax return
  - Copy of most recent check or check stub

- **Social Security Retirement:**
  - Benefit statement for current year
  - Copy of most recent bank statement showing direct deposit
  - Copy of most recent check or check stub

- **Supplemental Security Income:**
  - Benefit statement for current year
  - Copy of most recent bank statement showing direct deposit
  - or copy of most recent check or check stub

- **Social Security Disability:**
  - Benefit statement for current year
  - Copy of most recent bank statement showing direct deposit
  - Copy of most recent check or check stub

- **Unemployment:**
  - Unemployment award letter on company letterhead indicating amount and time period covered
  - Copy of most recent unemployment check or unemployment check stub

- **Alimony/Child support:**
  - Court award letter indicating amount and time period covered
  - Child Support Enforcement Agency letter
  - Letter from attorney stating amount and time period covered
  - Copy of one month's check
  - Bank statement with amount indicated

- **Veterans Benefits:**
  - Benefit statement or current year
  - Copy of most recent bank statement showing direct deposit
  - Copy of most recent check
  - Check stub

- **Pension/Retirement:**
  - Benefit statement for current year
  - Copy of most recent bank statement showing direct deposit
  - Copy of most recent check
  - Check stub

- **Other:**
  - Benefits statement
  - Award letter
  - Bank statement from payer/source
  - Copy of check(s)
  - Judgment statement

FLORIDA DEPARTMENT OF HEALTH

COLLIER COUNTY HEALTH DEPARTMENT
3339 East Tamiami Trail, Suite 145 , Building H,
Naples, FL. 34112

Mailing address:
P. O. Box 429, Naples, FL. 34106-0429

Collier County Health Department
Caring...Committed...Helping...Dedicated
To the Wellness of Our Community

FAX COVER SHEET

To:	Vaccine Access Program
Company:	GlaxoSmithKline
Fax Number:	1-877-822-1555
Phone Number:	1-877-822-2977
From:	Laura Levine, RN
Fax Number:	239-252-8808
Phone Number:	239-252-6837
Subject:	Applications
Pages:	
Sent at	

MESSAGE:

Please call me directly with any questions related to these applications.

Thank you.

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

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

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

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

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

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

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:** _____

GSK VACCINES ACCESS PROGRAM

GlaxoSmithKline

Phone: 1-877-VACC-911 (877-822-2911)
Fax: 877-822-1555

The GSK Vaccines Access Program was established to provide GlaxoSmithKline vaccines to qualified patients. This form is to be used for patients already enrolled in the Program and who need subsequent doses of vaccine. Healthcare prescribers that purchase and administer these vaccines are eligible to register for the program. Additional information related to the program 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.

DOSE AUTHORIZATION REQUEST FORM

SECTION 1: PRESCRIBER INFORMATION

Prescriber enrollment ID# _____

Prescriber name: _____ SLN# _____ Expiration date: ___/___/____

VACCINE REPLENISHMENT SHIPPING ADDRESS:

Shipping address: _____

City: _____ State: _____ Zip code: _____

Phone number: _____ Fax number: _____

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

SECTION 2: PATIENT INFORMATION

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

Patient date of birth:
_____

SECTION 3: DOSE RELEASE

58160-815-32- Twinrix®- Hepatitis A Inactivated & Hepatitis B (Recombinant) Vaccine	☐ Dose 1	☐ Dose 2	☐ Dose 3	
58160-815-32- Twinrix® Accelerated Dosing- Hepatitis A Inactivated & Hepatitis B (Recombinant) Vaccine	☐ Dose 1	☐ Dose 2	☐ Dose 3	☐ Dose 4
58160-830-32- Cervarix® - Human Papillomavirus Bivalent (Types 16 and 18) Vaccine, Recombinant	☐ Dose 1	☐ Dose 2	☐ Dose 3	
58160-842-32- Boostrix® - Tetanus Toxoid, Reduced Diphtheria Toxoid & Acellular Pertussis Vaccine, Adsorbed	☐ Dose 1			
58160-826-32- Havrix ®- Hepatitis A Vaccine	☐ Dose 1	☐ Dose 2		
58160-821-32- Engerix-B®- Hepatitis B Vaccine, Recombinant	☐ Dose 1	☐ Dose 2	☐ Dose 3	

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 acknowledged in the above Section 3 is indicated medically for the identified patient. I certify to the best of my knowledge, the information on this Dose 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 federal and state authorizations and consents 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 for any medication provided by GSK Vaccines Access Program.

Prescriber signature: _____ Date: _____

REMEMBER: An incomplete Dosage Authorization Request form will delay processing.Call 1-877-822-2911 with questions about the form.

- ☐ **Complete and sign the form.**
- ☐ **Applicants** must be 19 or older, **Cervarix® Applicants** must be female, ages 19-25 years
- ☐ **Fax the completed form** to 1-877-VAC-1555 (1-877-822-1555) for approval.
- ☐ **Obtain approval** before administering the vaccine. Notification of approval or denial is sent within approximately 10 minutes.

FLORIDA DEPARTMENT OF HEALTH

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: ____Women's Health Foundation_____ Phone #: __(239) 252-2580_____

Address: ___3339 Tamiami Trail East, Naples, Florida 34112_____ Fax #:_____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: __Collier County Health Department _____ Phone #: __(239) 252-8207_____

Address: ____3339 Tamiami Trail East, Naples, Florida 34112_____ Fax #: ____(239) 252-8808_____

Other method of communication: ___Hand delivery of information from WHF to CCHD Adult Health Clinic_____

INFORMATION TO BE DISCLOSED: (Initial Selection)

___x__ General Medical Record(s), including STD and TB _____ Progress Notes ___x__ History and Physical Results

__x___ Immunizations _____ Family Planning ___x_ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s)) _____

__X__ Other: (specify) ____Financial information_____

I specifically authorize release of information relating to: (initial selection)

_____HIV test results for non-treatment purposes _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _x___ Other (specify)_____Eligibility for vaccine patient assistance programs_

EXPIRATION DATE: This authorization will expire one year after the date signed below. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Client/Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

Client Name: _____

ID#: _____

DOB: _____

DH 3203, Approved November 2008
(Stock Number: 5744-000-3203-1)

Original: To File **Copy:** To Client **Copy:** To Accompany Disclosure