

Pfizer Patient Assistance Program: Instructions for Group A Enrollment Form

This enrollment form is for patients who would like to apply to receive any of the Group A medicines found below for free through the *Pfizer Patient Assistance Program*.

Important: If you would like to apply to receive Lyrica® (pregabalin) for free through the Pfizer Patient Assistance Program, please visit www.PfizerRxPathways.com and download the Group D application.

For help with any other Pfizer medicines, or to learn about Pfizer's other assistance programs, please call 844-989-PATH (7284) to speak with a Medicine Access Counselor (M-F, 8:00 am – 6:00 pm ET).

Do I Qualify for Free Medicine Through the *Pfizer Patient Assistance Program*?

You should complete this enrollment form if you:






✓ Have been prescribed a Pfizer **Group A** medicine, including:

- **Arthrotec®** (diclofenac sodium/misoprostol)
- **Caduet®** (amlodipine besylate/atorvastatin calcium)
- **Caverject®** (alprostadil for injection)
- **Celebrex®** (celecoxib capsules)
- **Celontin®** (methsuximide capsules)
- **Chantix®** (varenicline)
- **Cleocin®** (clindamycin)
- **Depo®-Estradiol** (estradiol cypionate injection)
- **Depo-Provera®** (medroxyprogesterone acetate injectable suspension)
- **Depo-subQ Provera 104®** (medroxyprogesterone acetate injectable suspension 104 mg/0.65 mL)
- **Detrol®** (tolterodine tartrate)
- **Detrol® LA** (tolterodine tartrate extended release capsules)
- **Dilantin®** (phenytoin oral suspension, phenytoin, and extended phenytoin sodium)
- **Duavee®** (conjugated estrogens/bazedoxifene)
- **Estring®** (estradiol vaginal ring)
- **Feldene®** (piroxicam)
- **Flector® Patch** (diclofenac epolamine topical patch)
- **Fragmin®** (dalteparin sodium)
- **Glyset®** (miglitol)
- **Heparin®** (sodium injection)
- **Inspira®** (eplerenone)
- **Lincocin®** (lincomycin)
- **Menest®** (esterified estrogens)
- **Mycobutin®** (rifabutin)
- **Nicotrol®** (nicotine)
- **Nitrostat®** (nitroglycerin)
- **Norpace®** (disopyramide phosphate)
- **Phospholine Iodide®** (echothiophate iodide)
- **Premarin®** (conjugated estrogens)
- **Premarin®** (conjugated estrogens) vaginal cream
- **Premphase®** (conjugated estrogens plus medroxyprogesterone acetate tablets)
- **Prempro®** (conjugated estrogens/medroxyprogesterone acetate) tablets
- **Pristiq®** (desvenlafaxine)
- **QuilliChew ER™** (methylphenidate hydrochloride)
- **Quillivant XR®** (methylphenidate hydrochloride)
- **Relpax®** (eletriptan HBr)
- **Skelaxin®** (metaxalone)
- **Synarel®** (nafarelin acetate)
- **Tikosyn®** (dofetilide)
- **Toviaz®** (fesoterodine fumarate)
- **Trecator®** (ethionamide tablets)
- **Viagra®** (sildenafil citrate) tablets
- **Zarontin®** (ethosuximide)

✓ Live in the United States or a U.S. territory

✓ Have no prescription coverage, or not enough coverage, to pay for your Pfizer medicine

✓ Meet certain income limits (see chart below):

| No. of People in Your Household | Total Monthly Income Before Taxes | Total Annual Income Before Taxes |
|---|-----------------------------------|----------------------------------|
|  | Less Than or Equal to \$4,020 | Less Than or Equal to \$48,240 |
|  | Less Than or Equal to \$5,413 | Less Than or Equal to \$64,960 |
|  | Less Than or Equal to \$6,807 | Less Than or Equal to \$81,680 |
|  | Less Than or Equal to \$8,200 | Less Than or Equal to \$98,400 |
|  | Less Than or Equal to \$9,595 | Less Than or Equal to \$115,120 |

If you live in Alaska or Hawaii, or have a household of greater than 5 members, please call 866-706-2400.

Note: Income limits are subject to change on an annual basis; current limits reflect 2017 Federal Poverty Level Guidelines.

The *Pfizer Patient Assistance Program* is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

P.O. Box 66585, St. Louis, MO 63166-6585

T: 866-706-2400

F: 866-470-1748

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Group A

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How Can I Apply?

Please follow the checklist below when submitting your application.



Fill out and sign the patient section of this enrollment form.



Ask your prescriber to fill out and sign the prescriber section of this enrollment form.

Note: Please do NOT send in patient medical records or any other patient documentation that has not been requested. Enrollment forms will be rejected if these additional materials are submitted.

✓ Gather the following required documents:

✓ Completed and signed enrollment form

Note: Please do not send in the Instructions, and please retain the HIPAA form for your own records.

✓ A photocopy of one of the following documents that shows your total annual income:

- Pages 1 & 2 of your previous year's federal tax return (*form 1040 or 1040EZ*)
- Wage and tax statements (*W-2 forms*)
- Two recent paycheck stubs
- Social security, pension, or railroad retirement statements (*SSA-1099 or similar*)
- Statements of interest, dividends, or other income (*1099-INT, 1099, 1099-DIV, or similar forms*)

✓ A photocopy of the front and back of your prescription coverage card (*for patients who have prescription coverage only*)

✓ Make a photocopy of your enrollment documentation, as it typically will not be returned to you

✓ Mail, or have your prescriber fax (with an office cover page), your enrollment documentation to:

Pfizer Patient Assistance Program
P.O. Box 66585
St. Louis, MO 63166-6585
Fax: 866-470-1748

After Applying, What Can I Expect?

You will be notified of your status within 2-3 weeks of submitting your enrollment form. If you have been accepted, you will be sent a letter that provides you with your enrollment term and next steps on how you will receive your medicine through the program.

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Group A

Enrollment Form for Group A Medicines: PATIENT SECTION



PATIENT INFORMATION

1

Patient Name: _____

Patient Address: _____ City: _____ State: _____ Zip Code: _____

E-Mail: _____ Telephone: _____

Total Number of People Within Household (including applicant): _____

Total Annual Income for Entire Household: \$ _____

Your annual household income includes current annual salary, Social Security, unemployment insurance benefits, and workers' compensation. The information you provide is subject to random audits and verification.

Please submit documentation to support the financial information you've listed. Attached is:

- Pages 1 & 2 of your most recent federal tax return W-2 form Other

PRESCRIPTION COVERAGE INFORMATION

2

Do you have prescription coverage? Yes (If Yes, please complete this section) No (If No, skip to section 3)

Is the Pfizer medicine you have been prescribed covered on your prescription plan? Yes No

Please check the 1 box that best describes your coverage type:

- Public Prescription Coverage** (Government-provided coverage, including but not limited to: Medicare Part D/Medicaid/VA)
- Private Prescription Coverage** (Coverage provided through your employer or coverage that you purchased through a state health insurance marketplace)

Reminder:

Please make a photocopy of the front and back of your prescription coverage card and submit it with your completed enrollment form.

PATIENT PRIVACY AND CONSENT (Read and sign below):

3

The information you provide will be used by Pfizer, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve the *Pfizer Patient Assistance Program*, to communicate with you about your experience with the *Pfizer Patient Assistance Program*, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

By signing below, I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true and accurate to the best of my knowledge.

I understand that:

- Completing this enrollment form does not guarantee that I will qualify for the *Pfizer Patient Assistance Program*.
- Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medicines supplied by the *Pfizer Patient Assistance Program* shall not be sold, traded, bartered, or transferred.
- Pfizer reserves the right to change or cancel the *Pfizer Patient Assistance Program*, or terminate my enrollment, at any time.
- The support provided through this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by Pfizer through the Pfizer Patient Assistance Program:

- I will promptly contact the *Pfizer Patient Assistance Program* if my financial status or insurance coverage changes.
- I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription drugs.
- I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans.
- I will notify my insurance provider of the receipt of any medicines through the *Pfizer Patient Assistance Program*.
- I have a signed copy of a current and completed HIPAA Authorization Form on record with my Prescriber so that my Prescriber may share health information about me with the *Pfizer Patient Assistance Program*, Pfizer Inc, and the Pfizer Patient Assistance Foundation Inc.



Signature of Patient

(Parent or guardian, if under 18 years of age)

X

Date: _____

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Group A [1 of 2]



REMINDER: Please do NOT send in patient medical records, or any other patient documentation that has not been requested. Enrollment forms will be rejected if these additional materials are submitted.

PRESCRIBER INFORMATION

1

Prescriber Name & Title:

DEA #:

State License #:

Office Ship-to Address:

City:

State:

Zip Code:

Phone:

Fax:

Prescriber E-mail Address:

PRESCRIPTION ORDER INFORMATION

2

This is only valid for use with the *Pfizer Patient Assistance Program*, and it serves as the prescription for the patient's first order (up to a 90-day supply) through the program. Reorders must be placed throughout a patient's enrollment at www.PfizerPAP.com, or via our automated reordering system at 855-742-7497.

Patient Name:

Product Name:

Strength:

Quantity for 90 days:

Product Name:

Strength:

Quantity for 90 days:

Product Name:

Strength:

Quantity for 90 days:

PRESCRIBER PRIVACY AND CONSENT *(Read and sign below)*

3

The information you provide will be used by Pfizer to improve and tailor our products and services to better serve you. The information will also be used by the Pfizer Patient Assistance Foundation™ and parties acting on their behalf to administer and improve the *Pfizer Patient Assistance Program*, to communicate with you about your experience with the *Pfizer Patient Assistance Program*, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

By signing below, you, the Prescriber, understand and agree to the following:

- I certify that the information provided is current, complete, and accurate to the best of my knowledge.
- I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient.
- I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable.
- I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable.
- Any medications supplied by Pfizer as a result of this enrollment form are for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement.
- The medicine will be provided only to this eligible and enrolled patient at no charge of any kind.
- Pfizer may contact the patient directly to confirm the receipt of medications.
- The information provided on this enrollment form is subject to random audits and verification.
- Pfizer may change or cancel this program at any time; Pfizer also reserves the right to terminate my patient's enrollment at any time.
- I will notify the *Pfizer Patient Assistance Program* immediately if the Pfizer product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes.
- I have a signed copy on file of my patient's current and completed HIPAA Authorization Form so that I may share patient health information with the *Pfizer Patient Assistance Program*, Pfizer Inc, and the Pfizer Patient Assistance Foundation Inc.



Signature of Prescriber

X

Date:

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HIPAA Authorization Form for the Disclosure of Patient Information
FOR PFIZER INC. AND THE PFIZER PATIENT ASSISTANCE FOUNDATION, INC.
PFIZER ASSISTANCE PROGRAMS

DO NOT SUBMIT THIS FORM WITH YOUR APPLICATION—IT IS FOR PATIENT AND PRESCRIBER RECORDS ONLY

To the Patient: Pfizer Inc. and the Pfizer Patient Assistance Foundation, Inc. offer patient assistance programs (the “Program”) to help patients who qualify obtain certain Pfizer medicines at no cost. In order to determine your eligibility for the Program and to administer your participation in the Program if you are accepted, Pfizer, along with its affiliated companies and contractors who administer the Program, needs to obtain certain information about you from your physician (who is also called your “Doctor” in this form). **Please complete this authorization, sign and date it, and return it to your doctor.**

To the Physician: **Please retain the original signed authorization with the patient’s records and provide a copy to the patient. You do not need to return this patient authorization to Pfizer.**

I request and authorize my Doctor, _____, to give Pfizer Inc., including representatives and contractors who work on behalf of Pfizer in this Program, and Express Scripts, Inc. (collectively, “Pfizer”), my protected health information, including but not limited to information about my medical condition and treatments, which is necessary to determine my eligibility for the Program and for my continuing participation in the Program if I am accepted, to administer the Program, to account for my withdrawal if I decide to stop participating in this Program, and to evaluate patient satisfaction and the Program’s overall effectiveness. The type of information that can be given under this authorization may include:

- My name and birth date
- My address and telephone number
- My Social Security number
- Financial information about me
- Information about my health benefits or health insurance coverage
- Information on my medical condition, as necessary

I understand that I may refuse to sign this authorization and that it is strictly voluntary. Further, I understand that my Doctor may not condition the provision of my treatment on my signing this authorization.

I know that I can cancel (revoke) this authorization at any time by writing to my Doctor at _____. If I cancel this authorization, then my Doctor will stop providing Pfizer, and its representatives, with information about me. However, I cannot cancel actions that have already been taken by relying on my authorization.

I understand that once my Doctor gives Pfizer information about me based on this authorization, federal privacy laws may not prevent Pfizer from further disclosing my information. I also understand that signing this authorization does not guarantee that I will be accepted into a Pfizer patient assistance program.

This authorization will expire 1 year after the date it is signed, below, or one (1) year after the last date I receive medicines under the Program, whichever is later, or as required by state law.

Patient or Personal Representative of Patient *{If personal representative, indicate authority to sign on behalf of Patient (if applicable)}*

Signature _____

Date _____

Name (please print) _____

Please return the signed form to your Doctor. You are entitled to a copy for your records.