

# Pfizer Patient Assistance Program: Instructions for Group C Enrollment Form

The Pfizer Patient Assistance Program for Vaccines is a product replacement–based assistance program that provides eligible patients with Prevnar 13<sup>®</sup> (Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM<sub>197</sub> Protein]) and Trumenba<sup>®</sup> (Meningococcal Group B Vaccine) for free through their doctor’s office. Through this program, prescribers’ purchased stock of the vaccine is replenished when administered to patients approved for assistance through the Pfizer Patient Assistance Program.






This enrollment form is designed for Prescribers who have patients who need help paying for their Pfizer vaccines.

If your patients need help with any other Pfizer medicines, or you would like to learn about Pfizer’s additional assistance options, please call 844-989-PATH (7284) to speak with a Medicine Access Counselor (M-F, 8:00 am – 6:00 pm ET).

## Does Your Patient Qualify for Vaccine Replacement?

To be eligible for assistance, your patient must:

- ✓ Have no insurance or prescription coverage for the vaccine needed
- ✓ Reside in the United States
- ✓ Meet certain age requirements:
  - Prevnar 13<sup>®</sup>: Be at least 18 years of age
  - Trumenba<sup>®</sup>: Be between 19 and 25 years of age
- ✓ 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 \$4,047	Less Than or Equal to \$48,560
	Less Than or Equal to \$5,487	Less Than or Equal to \$65,840
	Less Than or Equal to \$6,927	Less Than or Equal to \$83,120
	Less Than or Equal to \$8,367	Less Than or Equal to \$100,400
	Less Than or Equal to \$9,807	Less Than or Equal to \$117,680

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 2018 Federal Poverty Level Guidelines.

## How Can I Apply on Behalf of My Patient?

### 1 Call the Pfizer Patient Assistance Program at 866-706-2400 to obtain a vaccine replacement approval #



Upon confirming your patient’s eligibility with a Pfizer patient assistance representative over the phone, you will be provided with a vaccine replacement approval number.

Please note: Prescribers must verify their patient’s eligibility and obtain a unique vaccine replacement approval number from the Pfizer Patient Assistance Program over the phone before they can submit a completed enrollment form, or administer their own purchased stock of a Pfizer vaccine to their patient in need. The approval number given is based on the information provided over the phone, and it does not guarantee vaccine replenishment. A completed enrollment form, indicating that a patient meets all eligibility requirements, must be received via fax within 30 days in order for replenishment to officially be processed.

### 2 Complete this enrollment form and fax it (with an office cover page) to 866-230-1678



Within 30 days of receiving a vaccine replacement approval #, please complete pages 2 and 3 of this enrollment form with your patient and fax it to the Pfizer Patient Assistance Program at 866-230-1678.

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.

# Enrollment Form for Group C 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.

Do you have insurance or prescription coverage for your Pfizer vaccine?  Yes  No

For Prevnar 13®: Are you at least 18 years of age?  Yes  No

For Trumenba®: Are you between the age of 19 and 25?  Yes  No

## PATIENT PRIVACY AND CONSENT (Read and sign below):

2

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 I meet the eligibility criteria for the *Pfizer Patient Assistance Program* and that the information provided on this application is complete and accurate.

### I understand that:

- Completing this application form does not guarantee that I will qualify for assistance through the *Pfizer Patient Assistance Program*.
- Pfizer may verify the accuracy of the information I have provided and may ask for additional information to confirm my eligibility.
- Pfizer may obtain information from my credit profile from Experian Health for the purpose of verifying my income eligibility for the *Pfizer Patient Assistance Program*.
- Pfizer reserves the right to change or cancel the *Pfizer Patient Assistance Program*, or terminate my enrollment, at any time.
- Any vaccine supplied by the *Pfizer Patient Assistance Program* shall not be sold, traded, bartered, or transferred.
- The support provided through this program is not contingent upon any future purchase.

### I certify and attest that if I receive a Pfizer vaccine through the *Pfizer Patient Assistance Program*:

- I will not seek reimbursement or credit for this vaccine from any insurer, health maintenance organization, or government program.
- I have completed and signed a HIPAA Authorization Form and submitted it to my Prescriber.



Signature of Patient

X

Date:

**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.**

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# Enrollment Form for Group C Medicines: PRESCRIBER SECTION



## PRESCRIBER INFORMATION

1

Prescriber Name & Title:

DEA #:

State License #:

NPI #

Office Ship-to Address:

City:

State:

Zip Code:

Phone:

Fax:

Prescriber E-mail Address:

2

## VACCINE INFORMATION *(To be completed after patient eligibility is confirmed over the phone by a Pfizer patient assistance representative)*

Prevnar 13<sup>®</sup>: 0.5 mL Prefilled Syringe

Trumenba<sup>®</sup>: 0.5 mL Prefilled Syringe

Two-Dose Schedule

Three-Dose Schedule

Vaccine Replacement Approval #:

Vaccine Lot #:

Date of Administration:

You must provide the lot number of the vaccine administered from your commercial stock, as well as the date of its administration, in order for replacement product to be provided by the Pfizer Patient Assistance Program. For Trumenba<sup>®</sup>, please just provide the lot number of the first dose of the vaccine administered. For additional replacement doses of Trumenba<sup>®</sup> needed throughout your patient's 6-month enrollment, please call 1-866-706-2400.

As a reminder, you may not administer your patient's vaccine until you have received approval for replacement through the Pfizer Patient Assistance Program.

3

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

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.

### I understand that:

- My patient must meet the Pfizer Patient Assistance Program eligibility criteria in order to qualify for assistance.
- The product I receive is not a sample, but a replacement of product I previously purchased.
- Any vaccine ultimately supplied by Pfizer through the Pfizer Patient Assistance Program is for the sole use of the patient specified; it cannot be sold, traded, bartered, transferred, returned for credit, or submitted to any third party, such as Medicare or Medicaid, for reimbursement.
- Pfizer must receive a signed and completed application within 30 days in order to replenish the vaccine.
- The information provided on this application is subject to random audits and verification.
- Pfizer may change or cancel this program at any time.

### I certify and attest that:

- I have obtained all necessary authorizations from my patient to release personal and health information to Pfizer Inc. the Pfizer Patient Assistance Foundation, and any third parties acting on their behalf.
- I will neither charge my patient for the Pfizer vaccine, nor for its administration, if my patient is approved for assistance through the Pfizer Patient Assistance Program.



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.***