

Pfizer Patient Assistance Program: Enrollment Form for Group A Medicines

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*. 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:

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

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 \$3,960	Less Than or Equal to \$47,520
	Less Than or Equal to \$5,340	Less Than or Equal to \$64,080
	Less Than or Equal to \$6,720	Less Than or Equal to \$80,640
	Less Than or Equal to \$8,100	Less Than or Equal to \$97,200
	Less Than or Equal to \$9,480	Less Than or Equal to \$113,760

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 2016 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 [1]

Pfizer Patient Assistance Program: Enrollment Form for Group A Medicines

How Can I Apply?

Please follow the checklist below when submitting your application.



Fill out and sign the patient section (page 3) of this enrollment form.



Ask your prescriber to fill out and sign the prescriber section (page 4) of this enrollment form.

Gather the following required documents:

Completed and signed enrollment form (pages 3-4)

Note: Retain the HIPAA form on page 5 for your own records.

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

- 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)

For Lyrica® (pregabalin), include:

- **Original Prescription**
(Please note: If a pharmacy is included on the prescription, use Express Scripts Specialty Distribution Services or ESSDS)
- **Photocopy of your valid government-issued photo ID (e.g., driver's license, military ID)**
- **A list of your current medicines**
- **A list of any drug allergies you have**
- **If your documents will be sent via fax, please include an office cover page**
Note: If you live in New York, you must mail in your Lyrica prescription. We are unable to accept Lyrica prescriptions from the state of New York via fax.

For residents of Puerto Rico, the US Virgin Islands (USVI), or any other U.S. territory, include:

- **Your original prescription for all medicines**
- **A list of your current medicines**
- **A list of any allergies you have**

Make a photocopy of your enrollment form and income documentation, as these typically will not be returned to you

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

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

Note: Please do NOT send in patient medical records with the application form.

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 [2]

Enrollment Form for Group A Medicines: **PATIENT SECTION**



PATIENT INFORMATION

1

Patient Name:		Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Patient Address:		City:	State:	Zip Code:
E-Mail:	Telephone:	DOB (MM/DD/YY):		
Total Number of People Within Household (including applicant):		Total Annual Income for Entire Household:		

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

Most recent federal tax return W-2 form Other

For Lyrica® (pregabalin), include original prescription and a photocopy of your valid government-issued photo ID
 Note: If you live in New York, you must mail in your Lyrica prescription.

Do you have prescription coverage? Yes (If Yes, please complete section 2) No (If No, skip section 2)

PRESCRIPTION COVERAGE AND INSURANCE INFORMATION

2

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:

Medicare Part D (Federally funded program that provides prescription coverage to patients typically 65 years of age or older, or with disabilities)

Medicaid (A government-funded program providing prescription coverage to patients with limited income)

Private/Employer (Coverage often provided through an employer; examples of private prescription plans include: Blue Cross/Blue Shield, Cigna, Aetna, United Healthcare, Caremark)

State Insurance Marketplace (Also known as Health Insurance Marketplace exchanges, these are insurance plans typically sold through online marketplaces set up in accordance with the Patient Protection and Affordable Care Act)

Other (Including but not limited to: state-sponsored drug assistance programs; VA, military, retirement, or pension program drug coverage)

Primary Insurance Co. Name:	Plan Phone #:
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Member ID or Policy #: Group #:
Prescription Card Name:	Phone #:
RxBin #:	PCN #: Member ID or Policy #: Group #:

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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Enrollment Form for Group A Medicines: **PRESCRIBER SECTION**



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. In most cases, reorders can be placed throughout a patient's enrollment at www.PfizerPAP.com, or via our automated reordering system at 855-742-7497.

Patient Name: _____

DOB (MM/DD/YY): _____

Product Name: _____

Strength: _____

Directions: _____

Product Name: _____

Strength: _____

Directions: _____

Product Name: _____

Strength: _____

Directions: _____

PATIENT PHARMACY INFORMATION

3

Only for patients prescribed Lyrica® (pregabalin) or patients residing in Puerto Rico, the USVI, or other U.S. territories

Please include the following:

- Original prescription
(Please note: If a pharmacy is included on the prescription, use Express Scripts Specialty Distribution Services or ESSDS)
- A list of the patient's current medicines
- A list of the patient's drug allergies
- If documentation will be sent via fax, please include an office cover page

For patients who are prescribed Lyrica, also include a copy of your patient's valid government-issued photo ID

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

4

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: _____

Note: Please do NOT send in patient medical records with the application form.

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Group A [4]

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.

