Pfizer Patient Assistance Program:
Instructions for Group B Enrollment Form

This enrollment form is for patients who would like to apply to receive any of the Group B 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 Assistance?

To qualify for assistance, you must:

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

- **Rapamune®** *(sirolimus)*
- **Revatio®** *(sildenafil) tablets*
- **Revatio®** *(sildenafil) oral suspension*
- **Tygacil®** *(tigecycline) for injection*
- **Vfend®** *(voriconazole)*
- **Rapamune®** *(sirolimus) oral suspension*

✓ **Live in the United States or a US 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 $4,163	Less Than or Equal to $49,960
	Less Than or Equal to $5,637	Less Than or Equal to $67,640
	Less Than or Equal to $7,110	Less Than or Equal to $85,320
	Less Than or Equal to $8,583	Less Than or Equal to $103,000
	Less Than or Equal to $10,057	Less Than or Equal to $120,680

If you live in Alaska or Hawaii, or have a household of greater than 5 members, please call 855-239-9869.
Note: Income limits are subject to change on an annual basis; current limits reflect 2019 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.

PO Box 220574, Charlotte, NC 28222-0574 T: 1-855-239-9869 F: 1-855-998-6951

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Pfizer Patient Assistance Program:
Instructions for Group B Enrollment Form

How Can I Apply?

If you need immediate assistance with your Group B medicines, please call 1-855-239-9869

Please follow the checklist below when submitting your enrollment form.

Remember:

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

Ask your prescriber to fill out and sign the prescriber section and complete the prescription/order section of this enrollment form.

✓ **Gather the following required documents:**

- ✓ **Completed and signed enrollment form (pages 3-5)**

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

  - If you are currently enrolled and you are applying for re-enrollment, please include your Patient ID number on Page 3.

    You can find your Patient ID on any letter you've received from the *Pfizer Patient Assistance Program* or call us at 1-855-239-9869.

    Please note that we cannot process a re-enrollment request earlier than 6 months before your current enrollment period expires.

- ✓ **A photocopy of <u>one</u> 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)*
- ✓ **If you are enrolled in a Medicare Part D Plan, a photocopy of the front and back of your Medicare Part D card.**

✓ **Make a photocopy of your enrollment form and income documentation, as they will not be returned to you**

✓ **Have your prescriber fax (with an office cover page) or mail your application and enrollment documents to:**

Pfizer Patient Assistance Program
PO Box 220574
Charlotte NC 28222-0574
Fax: 1-855-998-6951

After Applying, What Can I Expect?

You will be notified of your status within 2-3 days of us receiving your enrollment form. If you have been accepted, you will be sent a letter that provides you with next steps on where you will receive your medicine and how it can be ordered throughout your enrollment period. Tygacil® (tigecycline) is shipped to the Prescriber's office and all other Group B medicines are typically shipped to a patient's home.

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Enrollment Form for Group B Medicines: PATIENT SECTION

1 PATIENT INFORMATION *(All fields are required):*

Patient Name:

I am currently enrolled in the *Pfizer Patient Assistance Program* and I want to re-enroll: ☐ **Yes** ☐ **No, I am a new patient**

Patient ID number (if you are a returning patient):

Patient Mailing Address:

City: **State:** **Zip Code:**

Patient Ship-to Address: *(if different from mailing address above)* **We will not ship to a PO Box.**

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

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

2 PRESCRIPTION COVERAGE AND INSURANCE INFORMATION

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

Prescription Copay/Cost (if known):

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

☐ **Private Prescription Coverage** (Coverage provided through your employer or coverage that you purchased through a state health insurance marketplace)

☐ **Public Prescription Coverage** (Government-provided coverage, including but not limited to: Medicare Part D/Medicaid/VA)

Are you enrolled in a Medicare Part D Prescription Drug Plan?

☐ **Yes** *(If Yes, please complete the information below)* ☐ **No** *(If No, skip to section 3)*

Provide your Medicare ID Number (HICN) or Medicare Beneficiary Number (MBI): _____

Provide your Part D Plan name and full address and send a copy of the front and back of your Medicare Part D card with your enrollment form: _____

3 PATIENT PRIVACY AND CONSENT *(Read and sign below)*

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 Pfizer's assistance programs, to communicate with you about your experience with Pfizer's assistance programs, to help you understand your insurance coverage and help you access certain Pfizer medicines through your insurance, 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 Pfizer's assistance programs.
- Pfizer may contact my insurer to help me understand my insurance coverage for certain products and may provide me support to obtain coverage through my insurer, including prior authorization and appeals support (if necessary and available).
- Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medicines supplied by Pfizer's assistance programs shall not be sold, traded, bartered, or transferred.
- Pfizer reserves the right to change or cancel Pfizer's assistance programs, or terminate my enrollment, at any time.
- The support provided through this program is not contingent on any future purchase.
- If I am enrolled in a Medicare Part D Plan and am eligible for the *Pfizer Patient Assistance Program*, Pfizer will notify my Part D Plan of my enrollment in the *Pfizer Patient Assistance Program*.

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 true out-of-pocket costs (TrOOP) for prescription drugs.
- I will not submit claims, 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 Pfizer's assistance programs, 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 B Medicines: PRESCRIBER SECTION

1 PRESCRIPTION/ORDER INFORMATION *(Complete for the following products only)*

- ☐ **Vfend:** 50 mg, 30-day supply
- ☐ **Vfend:** 50 mg, 60-day supply
- ☐ **Vfend:** 200 mg, 30-day supply
- ☐ **Vfend:** 200 mg, 60-day supply
- ☐ **Revatio:** 20 mg, 30-day supply
- ☐ **Revatio:** 20 mg, 60-day supply
- ☐ **Revatio Oral Suspension:** 112 mL, 10 mg/mL, 30-day supply
- ☐ **Revatio Oral Suspension:** 112 mL, 10 mg/mL, 90-day supply
- ☐ **Rapamune:** 0.5 mg, 30-day supply
- ☐ **Rapamune:** 0.5 mg, 90-day supply
- ☐ **Rapamune:** 1 mg, 30-day supply
- ☐ **Rapamune:** 1 mg, 90-day supply
- ☐ **Rapamune:** 2 mg, 30-day supply
- ☐ **Rapamune:** 2 mg, 90-day supply
- ☐ **Rapamune Oral Suspension:** 60 mL, 1 mg/mL, 30-day supply
- ☐ **Rapamune Oral Suspension:** 60 mL, 1 mg/mL, 90-day supply

PATIENT INFORMATION

First Name: **Last Name:**

Patient ID number *(if this is a returning patient):*

Date of Birth: **Phone #:**

Shipping Address *(If different than above)*: **City:** **State:** **Zip Code:**

PRESCRIPTION *(For full prescribing information, go to www.pfizer.com)*

Directions: **Quantity:** _____ **Refill:** _____ times

Drug Allergies: ☐ No ☐ Yes (If yes, please list medication(s) and associated reaction(s)):

Patient's Concurrent Medications:

Other Known Conditions:

Prescribing Physician (Please Print):

Prescriber Signature: **Date:**

Special Note: *In addition to completing this section, New York prescribers must submit a prescription on an original NY state prescription blank. Prescribers in all other states only need to submit a state-specific blank if it's required in their state, and the application is mailed.*

To e-Prescribe, send prescription via e-Prescribe to AmeriPharm/MedVantx, 2503 E. 54th Street N, Sioux Falls, SD 57104
(NPI Number: 1073692745; NCPDP number 4351968)

2 PHYSICIAN ADMINISTERED PRODUCTS *(Complete for Tygacil® (tigecycline) only)*

TREATMENT INFORMATION *(Indicate amount of Pfizer product requested for patient assistance)*

Patient Name:

Treatment Start Date:

Frequency of Treatment:

Vial Size: **# of Vials:**

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Enrollment Form for Group B Medicines: PRESCRIBER SECTION

3 Prescriber Information *To be completed by the prescriber (All fields are required):*

Prescriber Name & Title:

NPI #: **Tax ID #:**

State License #: **DEA #:**

Office Contact Name:

Name of Facility:

Facility Address:

City: **State:** **Zip Code:**

Phone: **Fax:**

Prescriber E-mail Address:

Supervising Physician Name and State License # (if applicable):

Specific ICD-10 code:

4 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 Pfizer's assistance programs, to communicate with you about your experience with Pfizer's assistance programs, 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 certify that my decision to prescribe a Pfizer product is based solely on my independent clinical judgment.
- I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient.
- Pfizer and/or its agents may use such information as necessary to provide reimbursement support on behalf of your patient for certain Pfizer products including services such as benefit verification, prior authorization, and appeals support.
- 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, nor will any cost related to it be applied toward the patient's true out-of-pocket costs (TrOOP).
- 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 Pfizer 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 Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc. Pfizer and/or its agents may use such information as necessary to provide reimbursement support on behalf of your patient for certain Pfizer products including services such as benefit verification, prior authorization, and appeals support.

Signature of Prescriber X **Date:**

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HIPAA Authorization Form for the Disclosure of Patient Information by Personal Physician

FOR PFIZER INC. AND THE PFIZER PATIENT ASSISTANCE FOUNDATION, INC. PFIZER ASSISTANCE PROGRAMS

DO NOT SUBMIT THIS FORM WITH YOUR ENROLLMENT FORM—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, need 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 including Lash Group (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

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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 one (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.

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