# *Pfizer RxPathways* Patient Assistance Program: ENROLLMENT FORM FOR GROUP B MEDICINES

*Pfizer RxPathways*, formerly known as Pfizer Helpful Answers®, is Pfizer's prescription assistance program that provides eligible patients with access to their Pfizer medicines.

**This enrollment form is intended for patients who would like to apply to receive any of the medicines listed under Group B on page 2 for free, or to receive help understanding and using their insurance benefits.**

If the Pfizer medicines you need help with are not in Group B, or you don't think you qualify for free medicine and would like to enroll to receive our savings card,* please call 877-744-5675 (M-F, 8 AM-8 PM ET).

**Terms and conditions apply.*

## Do I Qualify For Free Medicine Through *Pfizer RxPathways*?

**You are eligible for free medicine and should complete this enrollment form if you:**

- **Have been prescribed a Pfizer Group B medicine listed on page 2**
- **Live in the United States, Puerto Rico, or the US Virgin Islands**
- **Have no prescription coverage, or not enough coverage to pay for your Pfizer medicine**
- **Meet certain income limits, which vary by product and household size**

## How Can I Apply?

**For immediate assistance with access to specialty or oncology medicines, please call *Pfizer RxPathways* at 877-744-5675, M-F, during the hours of 8 AM-8 PM ET.**

1. **Fill out and sign the patient section of this enrollment form.**
2. **Ask your prescriber to fill out and sign the prescriber section and complete the prescription/order section of this enrollment form.**
3. **Gather the following required documents:**
   - ☐ Completed and signed enrollment form *(both Patient and Prescriber sides)*
   - ☐ A photocopy of **one** of the following documents that shows your total annual income: Previous year's federal tax return (form 1040 or 1040EZ); Two recent paycheck stubs; Wage and tax statements (W-2 forms); 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)
4. **Make a photocopy of your enrollment form and income documentation, as they typically will not be returned to you.**
5. **Mail all required documents or have your Prescriber fax to the number below:**

   *Pfizer RxPathways*
   P.O. Box 66976
   St. Louis, MO 63166-6976
   Fax: 800-708-3430
   Tel: 877-744-5675 (M-F, 8 AM-8 PM ET)

Pfizer reserves the right to change or cancel the *Pfizer RxPathways* program at any time.

GROUP A

### *Medicines typically prescribed by a Primary Care Physician*

Accuretic™ *(quinapril HCl/hydrochlorothiazide)*
Arthrotec® *(diclofenac sodium/misoprostol)* tablets
Caduet® *(amlodipine besylate/atorvastatin calcium)*
Caverject® *(alprostadil for injection)*
Celebrex® *(celecoxib capsules)*
Celontin® *(methsuximide capsules, USP)*
Chantix® *(varenicline)* tablets
Cleocin T® *(clindamycin phosphate)*
Cleocin HCI® *(clindamycin hydrochloride, USP)*
Cleocin Pediatric® *(clindamycin palmitate hydrochloride for oral solution, USP)*
Cleocin Phosphate® *(clindamycin phosphate, USP)*
Cleocin® *(clindamycin phosphate, USP)*
Colestid® *(colestipol hydrochloride)*
Colestid® *Flavored (colestipol hydrochloride)*
Cortef® *(hydrocortisone tablets, USP)*
Depo®-Estradiol *(estradiol cypionate injection, USP)*
Depo-Medrol® *(methylprednisolone acetate injectable suspension, USP)*
Depo-Provera® *(medroxyprogesterone acetate injectable suspension)*
Depo-subQ Provera 104® *(medroxyprogesterone acetate injectable suspension 104 mg/0.65 mL)*
Detrol® LA *(tolterodine tartrate extended release capsules)*
Detrol® *(tolterodine tartrate tablets)*
Dilantin® *(extended phenytoin sodium capsules, USP)*
Dilantin® *(phenytoin, USP)* Infatabs®
Dilantin-125® *(phenytoin oral suspension, USP)*
Duavee™ *(conjugated estrogens/bazedoxifene)*
Effexor XR® *(venlafaxine hydrochloride)* extended-release capsules
Estring® *(estradiol vaginal ring)*
Feldene® *(piroxicam)*
Glyset® *(miglitol tablets)*
Inspra™ *(eplerenone)*
Levoxyl® *(levothyroxine sodium tablets)*
Lincocin® *(lincomycin injection, USP)*
Lyrica® *(pregabalin)* capsules
Mycobutin® *(rifabutin capsules, USP)*
Nardil® *(phenelzine sulfate tablets, USP)*
Nicotrol® *(nicotine)*
Nitrostat® *(nitroglycerin, USP)*
Norpace® *(disopyramide phosphate capsules)*
Norpace® CR *(disopyramide phosphate extended-release capsules)*
Premarin® *(conjugated estrogens tablets, USP)*
Premarin® *(conjugated estrogens)* Vaginal Cream
Premphase® *(conjugated estrogens plus medroxyprogesterone acetate tablets)*
Prempro® *(conjugated estrogens/ medroxyprogesterone acetate tablets)*
Pristiq® *(desvenlafaxine)* extended-release tablets
Procardia XL® *(nifedipine)* extended release tablets
Procardia® *(nifedipine)* capsules
Protonix® *(pantoprazole sodium)*
Provera® *(medroxyprogesterone acetate tablets, USP)*
Quillivant™ XR *(methylphenidate hydrochloride)* for extended-release oral suspension
Relpax® *(eletriptan HBr)*
Skelaxin® *(metaxalone)*
Synarel® *(nafarelin acetate)* nasal solution
Tessalon® *(benzonatate)*
Tikosyn® *(dofetilide)*
Toviaz® *(fesoterodine fumarate extended release tablets)*
Trecator® *(ethionamide tablets)*
Viagra® *(sildenafil citrate)* tablets
Xalatan® *(latanoprost ophthalmic solution)*
Zarontin® *(ethosuximide capsules, USP)*

GROUP B

### *Medicines typically prescribed by a Specialist*

Aromasin® *(exemestane tablets)*
BeneFIX® *(coagulation factor IX (recombinant))*
Bosulif® *(bosutinib)*
Camptosar® *(irinotecan HCl injection)*
Ellence® *(epirubicin hydrochloride injection)*
Emcyt® *(estramustine phosphate sodium capsules)*
Idamycin PFS® *(idarubicin hydrochloride for injection, USP)*
Inlyta® *(axitinib)* tablets
Neumega® *(oprelvekin)*
Rapamune® *(sirolimus)*
Revatio® *(sildenafil)* tablets
Sutent® *(sunitinib malate)*
Torisel® *(temsirolimus)* injection
Tygacil® *(tigecycline)* for injection
Vfend® *(voriconazole)*
Xalkori® *(crizotinib)*
Xyntha® *(antihemophilic factor (recombinant), plasma/albumin-free)*
Zinecard® *(dexrazoxane for injection)*

GROUP C

### *Vaccines*

Prevnar 13® *(Pneumococcal 13-valent Conjugate Vaccine [Diphtheria CRM$_{197}$ Protein])*


© 2014 Pfizer Inc.

# Enrollment Form for Group B Medicines: PATIENT SECTION

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

Patient Name: | Gender: ☐ Male ☐ Female

Patient Address:

City: | State: | Zip Code:

E-Mail:

Telephone: (____) ____ – ____ | Date of Birth: (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 coverage? ☐ Yes *(If Yes, please complete section 2)* ☐ No

## 2 PRESCRIPTION COVERAGE AND INSURANCE INFORMATION (All fields are required):

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

Please check the one box that best describes your prescription coverage type:
☐ Medicare Part-D ☐ Medicaid ☐ Private/Employer ☐ State Healthcare Exchange ☐ Other

| | | | |
|---|---|---|---|
| Primary Insurance Co. Name: | | Phone #: (____) ____ – ____ | |
| Policy Holder Name: | | Policy Holder DOB: ___/___/___ | |
| Policy Holder SSN: ___–__–____ | | Policy #: | Group #: |
| Prescription Card Name: | | Phone #: (____) ____ – ____ | |
| RxBin #: | PCN# | Policy #: | Group #: |
| Secondary Insurance Co. Name: | | Phone #: (____) ____ – ____ | |
| Policy Holder Name: | | Policy Holder DOB: ___/___/___ | |
| Policy Holder SSN: ___–__–____ | | Policy #: | Group #: |
| Prescription Card Name: | | Phone #: (____) ____ – ____ | |
| RxBin #: | PCN# | Policy #: | Group #: |

## 3 SUTENT IN Touch, a free support program for patients starting treatment (For Sutent patients only):

☐ By checking this box, I agree that the information I provide will be used by Pfizer and parties acting on its behalf to send me the materials I requested and other helpful information and updates on SUTENT and/or my condition as well as related treatments, products, offers and services, including information about the Sutent In Touch Call Center. Pfizer may also use my information to communicate with me and my health care provider in relation to my treatment.

## 4 PATIENT PRIVACY AND CONSENT (Read and signature required 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 the *Pfizer RxPathways* program, products and services, to communicate with you about your experience with the *Pfizer RxPathways* program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

By signing below, 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 RxPathways*.
- 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 RxPathways* program shall not be sold, traded, bartered or transferred.
- Pfizer reserves the right to change or cancel the *Pfizer RxPathways* program, or terminate my enrollment, at any time.
- The support provided in 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 RxPathways program:***

- I will promptly contact *Pfizer RxPathways* 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 for any costs of medications.
- I will notify my insurance provider of the receipt of any medicines through *Pfizer RxPathways*.
- 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 RxPathways* program, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc.

| Signature of Patient *(Parent or guardian, if under 18 years of age)* | X | Date: |
|---|---|---|

## Enrollment Form for Group B Medicines:
# PRESCRIBER SECTION

**1**

| PRESCRIBER INFORMATION *(To be completed by the provider)* | | |
|---|---|---|
| Prescriber Name & Title: | | NPI #: |
| Payer Specific #: | | Tax ID #: |
| State License #: | | DEA #: |
| Office Contact Name: | | |
| Name of Facility: | | |
| Facility Address: | | |
| City: | State: | Zip Code: |
| Phone: ( ) – | Fax: ( ) – | |
| Ship to: ☐ Prescriber ☐ Patient | | |
| Prescriber E-mail Address: | | |
| Please provide diagnosis and specific ICD-9 code: | | |

**2**

### 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 RxPathways* programs, products, and services, to communicate with you about your experience with *Pfizer RxPathways*, and/or to send you materials and other helpful information and updates relating to *Pfizer RxPathways*.

**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 its dispensed to my patient, when applicable.
- I will comply with and abide by your 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 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 RxPathways* 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 RxPathways* program, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc.

| Signature of Prescriber | X | Date: |
|---|---|---|

 © 2014 Pfizer Inc. 

Enrollment Form for Group B Medicines:
# PRESCRIPTION / ORDER SECTION

**3**

- ☐ **Sutent:** ______ mg, 28-day supply
- ☐ **Xalkori:** 250 mg, 30-day supply
- ☐ **Bosulif:** ______ mg, 30 day supply
- ☐ **Sutent:** ______ mg, 42-day supply
- ☐ **Xalkori:** 200 mg, ______ day supply
- ☐ **Emcyt:** ______ mg, 90 day supply
- ☐ **Aromasin:** 25 mg, 90 day supply
- ☐ **Inlyta:** ______ mg BID, 30 day supply

- ☐ **Vfend:** 50 mg, 60 day supply
- ☐ **Rapamune:** .5 mg, 90 day supply
- ☐ **Rapamune:** 2 mg, 90 day supply
- ☐ **Vfend:** 200 mg, 60 day supply
- ☐ **Rapamune:** 1 mg, 90 day supply
- ☐ **Rapamune Oral Solution:** 1 mg
- ☐ **Revatio:** 20 mg, 90 day supply
- ☐ **Elelyso:** Total dose ______ units every ______ weeks, 28 day supply

- ☐ Xyntha Antihemophilic Factor, Plasma/Albumin-Free
- ☐ BeneFIX Coagulation Factor IX
  - ☐ 250 IU ☐ 500 IU ☐ 1,000 IU ☐ 2,000 IU Monthly dosage: ______ IU

## PATIENT INFORMATION

First Name: | Last Name:

Date of Birth: ___/___/___ | Phone #: (____) ____ – _____

Patient Address:

City: | State: | Zip Code:

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: ☐ Yes ☐ No If yes, please specify:

Patient's Concurrent Medications:

Prescribing Physician:

Prescriber Signature: X | Date:

Dispense as Written | May Substitute

*Special Note: New York Prescribers please submit prescription on an original NY State prescription blank, for all other States, if not faxed, must be on State specific blank if applicable for your State. The prescription is only valid if received by fax meeting IN and TN regulations.*

Please fax completed prescription form to *Pfizer RxPathways* at (800) 708-3430. Prescription valid for one year. Thank You.

**4**

## TRANSPLANT HISTORY *(For Rapamune Only, Complete Transplant History)*

Transplant Type: | Date of Transplant:

Transplant Facility: | Medicare Approved Facility: ☐ Yes ☐ No

**5**

## PHYSICIAN ADMINISTERED PRODUCTS *(For IV Oncology Products Only, Complete this Section)*

Please check the appropriate Pfizer product *(For full prescribing information, go to www.pfizeroncology.com)*

- ☐ Torisel® *(temsirolimus)* injection
- ☐ Idamycin® *(idarubicin hydrochloride)* injection
- ☐ Camptosar® *(irinotecan hydrochloride)* injection
- ☐ Neumega® *(oprelvekin)* injection
- ☐ Ellence® *(epirubicin hydrochloride)* injection
- ☐ Zinecard® *(dexrazoxane)* injection

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

Patient Name:

Treatment Start Date: ___/___/___ | Dosage:

Dosing Regimen:

Vial Size/# of Vials:

Save File | Print File



© 2014 Pfizer Inc.

# Pfizer Inc. and the Pfizer Patient Assistance Foundation, Inc.
# Patient Assistance Programs
# HIPAA Authorization Form for the Disclosure of Patient Information

**To Patient:**
The attached authorization is for you and your doctor. If you sign this authorization, you are allowing your doctor to give Pfizer health information about you that will help you get your Pfizer medications. An example of the type of information we need from your doctor would be the prescription for the medicine you need. This authorization is between you and your doctor only. **Please sign and give your doctor the original signed authorization and keep a copy for your records. This form should not be returned with your enrollment form.**

**To Physician:**
The attached authorization, when signed by your patient, documents the patient's permission for you to share certain medical and personal information with Pfizer in connection with Pfizer's patient assistance programs. This authorization is strictly for your records and should not be returned with your patient's enrollment form.

**To Patient and Physician, please note:**
Pfizer Helpful Answers® is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™, Inc.

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

**To the Patient:** Pfizer Inc. and the Pfizer Patient Assistance Foundation, Inc. offers 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 doctor. **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, ______________________________ ("Doctor"), to give Pfizer Inc., including representatives and contractors who work on behalf of Pfizer in this Program, information about me and my medical condition, 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 know that I can cancel 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 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.

**Patient or Personal Representative of Patient** ***{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.*