Pfizer Patient Assistance Program:
Instructions for Group A Enrollment Form

This enrollment form is for patients who would like to apply to receive any Group A Medicine 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 Group A medicine including:**

CELONTIN® *(methsuximide)* capsules
DEPO®-ESTRADIOL *(estradiol cypionate) injection*
DUAVEE® (conjugated estrogens/bazedoxifene)
ESTRING® (estradiol) vaginal ring
NORPACE® CR (disopyramide phosphate)
PREMARIN® (conjugated estrogens) tablets
PREMARIN® (conjugated estrogens) vaginal cream
PREMPHASE® (conjugated estrogens / edroxyprogesterone acetate)
PREMPHRO® (conjugated estrogens / medroxyprogesterone acetate)
SYNAREL® (nafarelin acetate)
TIKOSYN® (dofetilide)
TRECATOR® (ethionamide)
ZARONTIN® (Ethosuximide)

✓ **Have an FDA-approved indication for the requested product(s)**

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

✓ **Be treated by a healthcare provider licensed in the U.S. or a U.S. territory**

✓ **Be uninsured or government insured and unable to afford their copayment**

✓ **Meet certain income limits (income limit is 300% of the federal poverty level adjusted for family size)**

Pfizer Patient Assistance Programs:

Instructions for Group A Enrollment Form

This enrollment form is for patients who would like to apply to receive any Group A Medicine 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).

How Can I Apply?

Please follow the checklist below when submitting your application.

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 document or consent for electronic income verification**
  - ✓ **Completed and signed enrollment forms (pages 3-6)**
  - ✓ **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)*
  - ✓ **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 typically 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 8509
Somerville, NJ 08876
Fax: 866-470-1748

You can visit www.PfizerPAPConnect.com to help you place orders, track medicine shipments, and complete your enrollments in real time, at any time, from the convenience of your phone, tablet, or computer. The first step to begin using Pfizer PAP Connect is to register. The registration process only takes 1-2 minutes!

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

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

PATIENT INFORMATION

1

Patient Name:

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

Patient ID (if you are returning patient):

Patient Mailing Address:

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

Email: **Telephone:**

Total Number of People Within Household *(including applicant)*: **Total Annual Income for Entire Household:**

If you want your income verified electronically, please see Section 3, otherwise please submit documentation to support the financial information above. 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)*

PRESCRIPTION COVERAGE INFORMATION

2

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 one 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 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: _____

_____

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.

PATIENT SECTION

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

Patient Authorization for Electronic Income Verification (Optional, but may reduce application review time)

I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Report Act authorizing Pfizer Inc. to obtain information from my credit profile or other information from Experian Income View. I authorize Pfizer Inc. to obtain such information solely for the purpose of determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I am entitled to a copy of this authorization upon request. This Authorization shall be valid for one (1) year from the date of the signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to PO Box 8509, Somerville, NJ 08876, but this cancellation will not apply to any information already in use or disclosed through this Authorization.

Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements and agree to the outlined terms.

Signature of Patient (Parent or guardian, if under 18) X Date:

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.

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 Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc.

Signature of Patient (Parent or guardian, if under 18) X Date:

Enrollment Form for Group A Medicines: PRESCRIBER SECTION

3 PRESCRIBER INFORMATION

Prescriber Name & Title:

NPI #: State License#:

Office Contact Name: DEA #:

Name of Facility:

Facility Address:

City: State: Zip Code:

Phone: Fax:

PRESCRIPTION/ORDER INFORMATION

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.PfizerPAPConnect.com, or via our automated reordering system at 855-742-7497.

Patient Name:

Patient ID (if you are returning patient)

Product: Strength: Quantity for 90 days:

Product: Strength: Quantity for 90 days:

Product: Strength: Quantity for 90 days:

PRESCRIBER PRIVACY AND CONSENT

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 understand that completing this enrollment form does not guarantee that assistance will be provided to my patient.
- 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.
- 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.

4 Signature of Prescriber X Date:

PRESCRIBER Attestation

I, a licensed Doctor, certify that the product(s) I have prescribed to the patient on this Enrollment Form based on my independent medical judgement are for an FDA-approved indication. I understand that my patient must have an FDA-approved indication to be considered for enrollment in the Pfizer Patient Assistance Program and, if this certification is not signed and dated, my patient will be denied assistance.

Signature of Prescriber	X	Date:

HIPAA Authorization Form for the Disclosure of Patient Information

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

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.

I request and authorize my Doctor, _____, to give Pfizer Inc., including representatives and contractors who work on behalf of Pfizer in this Program, and 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 the 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 about my health condition, as necessary

I understand that I may refuse to sign this authorization and that 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 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.

Printed in USA/October 2021 FRMRXP101

03/20/2023 4:19PM (GMT-04:00)