Pfizer RxPathways® Patient Assistance Program:

Enrollment Form for **Group A** Medicines

Pfizer RxPathways is Pfizer's prescription assistance program that provides eligible patients with access to their Pfizer medicines.

This enrollment form is for patients who would like to apply to receive the Group A medicines found below for free. If you need help with any other Pfizer medicines or are interested in our savings program, please call 866-706-2400.

Do I Qualify for Free Medicine Through Pfizer RxPathways?

You should complete this enrollment form if all 4 statements on this checklist apply to you:

☐ **Have been prescribed a Pfizer Group A medicine, including:**

- ☐ **Arthrotec®** *(diclofenac sodium/misoprostol)*
- ☐ **Caduet®** *(amlodipine besylate/atorvastatin calcium)*
- ☐ **Caverject®** *(alprostadil for injection)*
- ☐ **Celebrex®** *(celecoxib capsules)*
- ☐ **Celontin®** *(methsuximide capsules)*
- ☐ **Chantix®** *(varenicline)*
- ☐ **Cleocin®** *(clindamycin)*
- ☐ **Colestid®** *(micronized colestipol hydrochloride)*
- ☐ **Cortef®** *(hydrocortisone tablets)*
- ☐ **Depo®-Estradiol** *(estradiol cypionate injection)*
- ☐ **Depo-Medrol®** *(methylprednisolone acetate injectable suspension)*
- ☐ **Depo-Provera®** *(medroxyprogesterone acetate injectable suspension)*
- ☐ **Depo-subQ Provera 104®** *(medroxyprogesterone acetate injectable suspension 104 mg/0.65 mL)*
- ☐ **Detrol®** *(tolterodine tartrate)*
- ☐ **Dilantin®** *(phenytoin oral suspension, phenytoin, and extended phenytoin sodium)*
- ☐ **Duavee®** *(conjugated estrogens/bazedoxifene)*
- ☐ **Effexor XR®** *(venlafaxine hydrochloride)*
- ☐ **Estring®** *(estradiol vaginal ring)*
- ☐ **Feldene®** *(piroxicam)*
- ☐ **Glyset®** *(miglitol)*
- ☐ **Inspra®** *(eplerenone)*
- ☐ **Lincocin®** *(lincomycin)*
- ☐ **Lyrica®** *(pregabalin) CV*
- ☐ **Mycobutin®** *(rifabutin)*
- ☐ **Nardil®** *(phenelzine sulfate)*
- ☐ **Nicotrol®** *(nicotine)*
- ☐ **Nitrostat®** *(nitroglycerin)*
- ☐ **Norpace®** *(disopyramide phosphate)*
- ☐ **Premarin®** *(conjugated estrogens)*
- ☐ **Premphase®** *(conjugated estrogens plus medroxyprogesterone acetate tablets)*
- ☐ **Prempro®** *(conjugated estrogens/ medroxyprogesterone acetate) tablets*
- ☐ **Pristiq®** *(desvenlafaxine)*
- ☐ **Procardia®** *(nifedipine)*
- ☐ **Quillivant XR™** *(methylphenidate hydrochloride) CII*
- ☐ **Relpax®** *(eletriptan HBr)*
- ☐ **Skelaxin®** *(metaxalone)*
- ☐ **Synarel®** *(nafarelin acetate)*
- ☐ **Tikosyn®** *(dofetilide)*
- ☐ **Toviaz®** *(fesoterodine fumarate)*
- ☐ **Trecator®** *(ethionamide tablets)*
- ☐ **Viagra®** *(sildenafil citrate)* tablets
- ☐ **Xalatan®** *(latanoprost)*
- ☐ **Zarontin®** *(ethosuximide)*

☐ **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:**

No. of People in Your Household	Total Monthly Income Before Taxes	Total Annual Income Before Taxes
1	Less Than or Equal to $3,923	Less Than or Equal to $47,080
2	Less Than or Equal to $5,310	Less Than or Equal to $63,720
3	Less Than or Equal to $6,697	Less Than or Equal to $80,360
4	Less Than or Equal to $8,083	Less Than or Equal to $97,000
5	Less Than or Equal to $9,470	Less Than or Equal to $113,640

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 2015 Federal Poverty Level Guidelines.

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How Can I Apply?

Please follow the checklist below for a step-by-step guide for applying to Pfizer RxPathways.

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 <u>one</u> 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)*

- ☐ **For Lyrica® *(pregabalin)*, include original prescription and a photocopy of your valid government-issued photo ID (e.g., driver's license, military I.D.) 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 or the US Virgin Islands (USVI), include your original prescription for all medicines**

☐ **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, your application to Pfizer RxPathways:**

Pfizer RxPathways
P.O. Box 66585
St. Louis, MO 63166-6585

Fax: 866-470-1748

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 Pfizer RxPathways.

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

Enrollment Form for Group A Medicines: PATIENT SECTION

1 PATIENT INFORMATION

Patient Name: **Gender:** ☐ Male ☐ 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

Do you have prescription 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 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: **Phone #:**

Policy Holder Name: **Policy Holder DOB:**

Policy Holder SSN: **Policy #:** **Group #:**

Prescription Card Name: **Phone #:**

RxBin #: **PCN #** **Policy #:** **Group #:**

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 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 A Medicines: PRESCRIBER SECTION

1 PRESCRIBER INFORMATION

Prescriber Name & Title:

DEA #: **State License #:**

Office / Ship-to Address:

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

Phone: **Fax:**

Prescriber E-mail Address:

2 PRESCRIPTION ORDER INFORMATION

This is only valid for use with Pfizer RxPathways®, 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: **Date:**

Patient Address: **DOB:** *(MM/DD/YY)*:

Product Name:	**Strength:**	**Directions:**
Product Name:	**Strength:**	**Directions:**
Product Name:	**Strength:**	**Directions:**

3 PATIENT PHARMACY INFORMATION *(Complete only for Lyrica® (pregabalin) or patients residing in Puerto Rico or the USVI)*

Please complete this section and attach an original prescription. Please include a copy of your patient's valid government-issued photo ID for Lyrica.

Drug Allergies: ☐ **Yes** ☐ **No** **If yes, please list all:**

List all prescription and over-the-counter medications the patient is currently taking:

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 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 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 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:**

Pfizer RxPathways P.O. Box 66585, St. Louis, MO 63166-6585 T: 866-706-2400 F: 866-470-1748 www.PfizerRxPath.com

HIPAA Authorization Form for the Disclosure of Patient Information

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