ENROLLMENT FORM: PATIENT APPLICATION

Please complete the form where applicable and return via mail or fax.

Pfizer RSVP
Leading the way to access
Reimbursement Solutions, Verification, and Payment HELPline

Phone 1-888-327-7787 or Fax 1-888-773-0121 PO Box 220574, Charlotte, NC 28222-0574

Please check the appropriate Pfizer product:

- ☐ Zyvox® *(linezolid)*
- ☐ Xyntha® Antihemophilic Factor *(recombinant)*, Plasma/Albumin-Free
- ☐ Rapamune® (*sirolimus*)
- ☐ BeneFIX® Coagulation Factor IX *(recombinant)*
- ☐ Revatio® *(sildenafil)*
- ☐ Vfend® (*voriconazole*)
- ☐ Tygacil® *(tigecycline)**

* *Reimbursement Services Only*

Patient Name:		Sex: ☐ Male ☐ Female
Patient Address:	E-mail:	
City:	State:	Zip Code:
Telephone (Day): ( ) –	(Evening): ( ) –	
Date of Birth (DOB): / /	U.S./Puerto Rico/U.S.V.I. Resident: ☐ Yes ☐ No	

INSURANCE INFORMATION (Include all insurance policies)

Do you have insurance? ☐ Yes ☐ No *(If yes, complete the information below or attach a photocopy of insurance card)*

Primary Insurance Co. Name:	Phone #: ( ) –	
Policy Holder Name:	Policy Holder DOB: / /	
Policy Holder SSN: – –	Policy #:	Group #:
Prescription Card Name:	Phone #: ( ) –	
Policy #:	Effective Date:	Group #:
Secondary Insurance Co. Name:	Phone #: ( ) –	
Policy Holder Name:	Policy Holder DOB: / /	
Policy Holder SSN: – –	Policy #:	Group #:
Prescription Card Name:	Phone #: ( ) –	
Policy #:	Effective Date:	Group #:

PATIENT FINANCIAL INFORMATION

Total Number of People Within Household (including applicant): _____

Total Annual Income for Entire Household: $_____ *(The current annual household income includes current annual salary, Social Security, unemployment insurance benefits and workers' compensation)*

Please submit documentation to support the financial information

Attached is: ☐ Most recent federal tax return (1040 form) ☐ W-2 form ☐ Other

We must receive proof of income to determine eligibility for assistance.

If you are required to file a federal tax return, please provide a signed copy. Proof of income may include documents such as: copy of most recent federal tax return, W-2 form(s), 1099 form, Social Security Award Letter or Check, or copy of three most recent pay stubs.

Patient Declaration – 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 application form does not guarantee that I will qualify for the RSVP Program.
- Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medications supplied with the RSVP Program shall not be sold, traded, bartered or transferred.
- Pfizer reserves the right to change or cancel the RSVP Program 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 RSVP Program:

- I will promptly contact the RSVP Program if my financial status or insurance coverage changes.
- I will not seek to have the medicine(s) or any cost from it (them) counted in my Medicare Part D out-of-pocket expenses for prescription drugs.
- I will not seek reimbursement or credit for any costs associated with 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 medicine(s) through the RSVP Program.

Pfizer & Pfizer Patient Assistance Foundation (PPAF) understand your personal & health information is private. The information you provide will only be used by Pfizer, PPAF & parties acting on their behalf to send you the materials you request & other helpful information and updates on the RSVP Program.

☐ By checking this box, I also agree that Pfizer and PPAF and companies acting on their behalf may send me materials about other health conditions, use my information to develop or improve products and services, or contact me in the future about my experience with the RSVP Program or other health-related topics.

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

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ENROLLMENT FORM: HEALTHCARE PROVIDER APPLICATION

Please read all information and print clearly.

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PRESCRIBER INFORMATION *(To be completed by the provider)*

Prescriber Name & Title:		**NPI #:**
Payer Specific #:	**Tax ID #:**	
State License #:	**DEA #:**	
Contact Name:		
Name of Facility:		
Facility Address:		
City:	**State:**	**Zip Code:**
Ship to: ☐ Prescriber ☐ Patient ☐ Other (please provide shipping address):		
Phone: (_____) _____ – _____	**Fax:** (_____) _____ – _____	
Prescriber E-mail Address:	**Prescriber Specialty:**	
Please provide diagnosis and specific ICD-9 code:		

PRESCRIBER CERTIFICATION

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I will notify RSVP immediately if the Pfizer product is no longer medically necessary for this patient's treatment. **I certify that the Pfizer product is medically necessary for this patient and I will be supervising the patient's treatments.** I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification and insurance information to Pfizer and their agents and representatives. I understand that any information provided is for the sole use of Pfizer and their agents and representatives to verify my patient's insurance coverage, to assess, if applicable, patient's eligibility for participation in the patient assistance program and to otherwise administer the RSVP program and related services. I understand that application to the patient assistance program does not guarantee that assistance will be obtained. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the patient assistance program, and I agree to immediately notify a RSVP representative if I become aware of changes in the patient's insurance status. I agree that RSVP may contact me for additional information relating to this application either by fax or any other form of communication, including but not limited to e-mail and telephone. I understand that I am under no obligation to prescribe any Pfizer product and that I have not received nor will I receive any benefit from Pfizer or their agents or representatives for prescribing a Pfizer product. I agree that I will not submit claims for product provided by the Patient Assistance Program

Pfizer and Pfizer Patient Assistance Foundation (PPAF) understand your information is private. Any information you provide will only be used by Pfizer, PPAF and parties acting on their behalf to administer the RSVP Program and to comply with applicable legal requirements.

☐ By checking this box, I also agree that Pfizer and PPAF and companies acting on their behalf may contact me about my experience with the RSVP Program to help improve services.

Prescriber Signature:	**X**	**Date:**

PRESCRIPTION *(This prescription form is not needed for Zyvox. For full prescribing information, go to www.pfizer.com)*

First Name:	**Last Name:**	
Date of Birth: ____/____/____	**Phone #:** (_____) _____ – _____	
Directions:		**Refills:** _____ times

Drug Allergies: ☐ Yes ☐ No **If yes, please specify:**

☐ **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

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

Prescribing Physician:

Prescriber Signature:	**X**	**Date:** ____/____/____

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

Transplant Type:	**Date of Transplant:**
Transplant Facility:	**Medicare Approved Facility:** ☐ Yes ☐ No

Please fax completed prescription form to RSVP at (888) 773-0121. Thank You. Prescription valid for one year.

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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 application.**

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 application.**

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.