INSTRUCTIONS FOR PATIENT APPLICATION

Am I Eligible for *Connection to Care*®?

You must meet the following criteria:

1. **You have been prescribed a Pfizer medicine**
   Many Pfizer medicines are available. For a list of available Pfizer medicines, please call 866-706-2400 or visit www.PfizerHelpfulAnswers.com
2. **You reside in the United States, Puerto Rico or the U.S. Virgin Islands**
3. **Your Total Gross Annual Household Income is at or below 2 times the Federal Poverty Level adjusted for family size (see chart)**
   - Total number of persons in household includes yourself and those for whom you are financially responsible
   - Total Gross Income includes incomes from all earners in the household before taxes and deductions

Total Number of People in Household	1	2	3	4	5
Annual Income (2010)	$21,660	$29,140	$36,620	$44,100	$51,580

For a household greater than 5 or if you live in Alaska or Hawaii, please call 866-706-2400

4. **You have either:**
   - **No insurance coverage or benefits for prescription medicines or;**
   - **You have prescription drug coverage and are experiencing financial hardship**
     Please complete the Hardship Assistance section on the Patient Application

How Can I Apply?

1. **Fill out and sign the patient side of the application form**
2. **Ask your Prescriber to fill out the prescriber side of the application form**
3. **Place all required documents together in a stamped envelope:**
   - ☐ Original completed and signed application form *(both Patient and Prescriber sides)*
   - ☐ Photocopies of proof-of-income documents *(please see Proof of Income section below)*
   - ☐ For Lyrica® (*pregabalin*), include original prescription and photocopy of your valid government issued photo ID (e.g., driver's license, military I.D., etc.)
   - ☐ For residents of Puerto Rico or U.S. Virgin Islands, include original prescription for all medicines
   - ☐ **Mail to:** **PFIZER *CONNECTION TO CARE* PROGRAM**
     PO BOX 66585
     ST. LOUIS, MO 63166-6585

For your information:

- Keep photocopies of your application and your original income documentation
- You will be notified of your status within 3-4 weeks of receipt of your application
- If you are accepted, you will receive your medicines through your Prescriber's office. For Lyrica® and patients residing in Puerto Rico and U.S. Virgin Islands medicines will be shipped to your home
- You must have a copy of a current and completed HIPAA Authorization Form on record with your Prescriber so that your Prescriber may share health information about you with the *Connection to Care* program, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc. *(You may have received this form with your application in the mail. To obtain an additional form please call, 866-706-2400 or visit www.PfizerHelpfulAnswers.com)*

What Proof of Income Do I Need to Apply?

Please provide us with one of the following items to show your total gross annual household income:

- Current pay check stubs or W-2 forms for all working members of you household
- Federal Tax Return (Form 1040 or 1040EZ) for the prior tax year
- If you are retired, please send your Social Security, pension or other income statements
- If you do not have any proof of income, please call 866-706-2400 for instructions

PATIENT APPLICATION

Please read all information on the separate Instructions sheet.
Print clearly in the shaded areas on the application.

Pfizer Rx CONNECTION TO CARE® PATIENT ASSISTANCE PROGRAM

1

Patient Name:			
Patient Address:			
City:		**State:**	**Zip Code:**
Telephone: (_____) _____ – _____		**Date of Birth: (MM/DD/YY):**	____ / ____ / ____
E-Mail *(optional)*:		**Gender:** ☐ Male ☐ Female	

2

Total Gross Annual Household Income: $
(see income guidelines on the instructions page)

Number of Persons in Household:
(include yourself and those you are financially responsible)

3

Do you have any insurance coverage for prescription drugs?

☐ **Yes** *If yes, go to section 4, 5 and 6 below* ☐ **No** *If no, go to section 5 and 6 below*

4

PATIENT HARDSHIP ASSISTANCE

If you responded **YES** to section 3 above, are facing financial hardship and have prescription drug coverage, please answer these questions:

a. Please check the box that best describes your prescription drug coverage:

☐ Medicare Part D ☐ Medicaid ☐ Employer ☐ Other

b. Patient Declaration of Hardship

☐ By checking this box, I certify that I am experiencing significant financial hardship, and because of this hardship, I am currently unable to pay for the Pfizer medicine prescribed to me.

5

PATIENT PRIVACY AND CONSENT

Pfizer and Pfizer Patient Assistance Foundation (PPAF) understand your personal and health information is private. The information you provide will only be used by Pfizer, PPAF and parties acting on their behalf to send you the materials you request and other helpful information and updates on the *Connection to Care* 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 *Connection to Care* program or other health-related topics.

6

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 *Connection to Care*.
- 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 *Connection to Care* program shall not be sold, traded, bartered or transferred.
- Pfizer reserves the right to change or cancel the *Connection to Care* 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 Connection to Care program:

- I will promptly contact *Connection to Care* 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 *Connection to Care*.
- 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 *Connection to Care* program, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc.

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

PRESCRIBER SECTION

Please read all information and print clearly in the shaded areas.

CONNECTION TO CARE® PATIENT ASSISTANCE PROGRAM

A

Prescriber Name:			
DEA #:		**State License #:**	
Office / Ship-to Address:		**Suite #:**	
City:		**State:**	**Zip Code:**
Office Telephone: (_____) _____ – _____		**Office Fax:** (_____) _____ – _____	
E-Mail Address *(optional)*:			

B

Medication Order Info *(90-day Supply)*. Please complete this section for <u>all</u> products for <u>U.S. residents</u>.

For Lyrica® *(pregabalin)* or resident of Puerto Rico and U.S. Virgin Islands, please see section C below.

Patient Name: _____ **Date:** _____

Patient Address: _____ **D.O.B.:** ____/____/____

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

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

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

This is only valid for use with the Pfizer Connection to Care patient assistance program.

C

PATIENT PHARMACY INFORMATION

For Lyrica® and patients residing in Puerto Rico and U.S. Virgin Islands, complete this section and attach original prescription. Please include a copy of your patient's valid government issues photo ID for Lyrica.®

Is the patient allergic to medications? ☐ No ☐ Yes If yes, please list all: _____

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

D

PRESCRIBER PRIVACY AND CONSENT

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 *Connection to Care* 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 *Connection to Care* program to help improve services.

E

By signing below, you, the Prescriber, understands and agrees to the following:

- Receive and secure patient's medication at your office until dispensed to your patient.
- Comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers.
- Any medications supplied by Pfizer as a result of this order 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.
- Pfizer may contact the patient directly to confirm receipt of medications.
- Pfizer may change or cancel this program at any time.
- The medicine will be provided only to this eligible and specific enrolled patient at no charge of any kind.
- If patient is applying for a Hardship Assistance, I certify that this medication order or attached controlled substance prescription is medically indicated for this patient, and I will be supervising the patient's treatments. To the best of my knowledge, this patient would not be able to obtain this medicine without assistance from *Connection to Care* for the reasons the patient has indicated in this application.
- 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 *Connection to Care* program, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc.

Original Signature of Prescriber	**X**	**Date:**

Connection to Care is part of Pfizer Helpful Answers®, a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation.™

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.