Pfizer Patient Assistance Program:
Instructions for **Group D** Enrollment Form

This enrollment form is for patients who would like to apply to receive **Lyrica®** ***(pregabalin)*** 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 to Receive Free Medicine Through the Pfizer Patient Assistance Program?

You should complete this enrollment form if you:

- ✓ **Have been prescribed Lyrica®**
- ✓ **Live in the United States or a U.S. territory**
- ✓ **Have no prescription coverage, or not enough coverage, to pay for your Lyrica®**
- ✓ **Meet certain income limits (see chart below):**

No. of People in Your Household	Total Monthly Income Before Taxes	Total Annual Income Before Taxes
1	Less Than or Equal to $4,020	Less Than or Equal to $48,240
2	Less Than or Equal to $5,413	Less Than or Equal to $64,960
3	Less Than or Equal to $6,807	Less Than or Equal to $81,680
4	Less Than or Equal to $8,200	Less Than or Equal to $98,400
5	Less Than or Equal to $9,593	Less Than or Equal to $115,120

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 2017 Federal Poverty Level Guidelines.

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

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Group D

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How Can I Apply?

Please follow the checklist below when submitting your application.

Fill out and sign the patient section of this enrollment form.

Ask your prescriber to fill out and sign the prescriber section of this enrollment form.

Note: Please do NOT send in patient medical records or any other patient documentation that has not been requested. Enrollment forms will be rejected if these additional materials are submitted.

✓ Gather the following required documents:

- ✓ **Completed and signed enrollment form**
  Note: Please do not send in the Instructions, and please retain the HIPAA form for your own records.
- ✓ **A photocopy of one of the following documents that shows your total annual income:**
  - Pages 1 & 2 of the 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)*
- ✓ **An original prescription from your Prescriber**
  - Note: If you live in New York, your Prescriber must send in your prescription via e-Prescribe to **ESSDS PAP Pharmacy**.
  - Please see the Prescriber section of this enrollment form for prescription requirements
- ✓ **A photocopy of your valid government-issued photo ID (e.g., driver's license, military ID)**
- ✓ **A photocopy of the front and back of your prescription coverage card (*for patients who have prescription coverage only*)**

✓ Make a photocopy of your enrollment documentation, as it will typically not be returned to you

✓ Mail, or have your prescriber fax (with an office cover page and fax banner), your enrollment documentation to:

Pfizer Patient Assistance Program
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 timing for when you can expect your first product shipment to be delivered to your home.

Enrollment Form for Group D Medicines: PATIENT SECTION

1 PATIENT INFORMATION

Patient Name: **Gender:** ☐ Male ☐ Female

Patient Ship-to Address (No P.O. Box):

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: $_____

Your annual household income includes current annual salary, Social Security, unemployment insurance benefits, and workers' compensation. The information you provide is subject to random audits and verification.

Please submit documentation to support the financial information you've listed. Attached is:

☐ Pages 1 & 2 of your most recent federal tax return ☐ W-2 form ☐ Other

☐ **Reminder: Please include original Lyrica® *(pregabalin)* prescription from your Prescriber and a photocopy of your valid government-issued photo ID with your submission.**
Note: If you live in New York, your Prescriber must send in your prescription via e-Prescribe to ESSDS PAP Pharmacy.

2 PRESCRIPTION COVERAGE INFORMATION

Do you have prescription coverage?

☐ **Yes (*If Yes, please complete the remaining questions in section 2)*** ☐ **No *(If No, skip to section 3)***

Is Lyrica® covered on your prescription plan? ☐ **Yes** ☐ **No**

Please check the 1 box that best describes your coverage type:

☐ **Public Prescription Coverage (Government-provided coverage, including but not limited to: Medicare Part D/Medicaid/VA)**

☐ **Private Prescription Coverage (Coverage provided through your employer, or coverage that you purchased through a state health insurance marketplace)**

☐ **Reminder: Please make a photocopy of the front and back of your prescription coverage card and submit it with your completed enrollment form.**

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 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.

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 the Pfizer Patient Assistance Program.
- 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 Patient Assistance Program shall not be sold, traded, bartered, or transferred.
- Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program, 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 the Pfizer Patient Assistance Program, Pfizer Inc, and the Pfizer Patient Assistance Foundation Inc.

Signature of Patient X **Date:**

The *Pfizer Patient Assistance Program* is a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation™.
The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

Enrollment Form for Group D Medicines: PRESCRIBER SECTION

***REMINDER:* Please do *NOT* send in patient medical records, or any other patient documentation that has not been requested. Enrollment forms will be *rejected* if these additional materials are submitted.**

1 PRESCRIBER INFORMATION

Prescriber Name & Title:

DEA #: **State License #:**

Office Address: **E-mail Address:**

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

Phone: **Fax:**

Supervising Physician *(if applicable)*:

2 PATIENT INFORMATION

Drug Allergies: ☐ **No** ☐ **Yes (If yes, please list medications and associated reactions):**

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

☐ **Reminder: Please attach an original Lyrica® *(pregabalin)* prescription with an original signature to this enrollment form.**

Prescription should include the following:

- Patient's First and Last Name
- Patient's Telephone Number
- Patient's Date of Birth
- Patient's Home Shipping Address (do not include a P.O. Box)

Do not include a pharmacy name on the prescription. If your prescription software requires a pharmacy name, please use "ESSDS PAP Pharmacy"

When sending:

- Please be sure to comply with your state-specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc
- Please adhere to your state prescription guidelines for a Schedule V controlled substance
- Please verify that the quantity, day supply, and directions all match on the prescription and that the prescriber is clearly indicated.

Please note:

- Prescriptions will be dispensed as written, as long as there is no more than a 90-day supply of medicine requested per fill.
- If refills are included on the original Rx, you or your patient may call 877-486-5367 to order them.
- New prescriptions should be faxed (with an office cover page, fax banner, and patient's shipping address listed) to 866-470-1748.

3 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 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.

I understand that:

- 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 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 the 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 the Pfizer Patient Assistance Program 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 Patient Assistance Program, Pfizer Inc, and the Pfizer Patient Assistance Foundation Inc.

Signature of Prescriber X **Date:**

The *Pfizer Patient Assistance Program* is a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation™.
The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

HIPAA Authorization Form for the Disclosure of Patient Information

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

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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 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.

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