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 branded 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 (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 (2009)	$21,660	$29,140	$36,620	$44,100	$51,580

Please visit www.aspe.hhs.gov/poverty/ for information on Federal Poverty Level guidelines.
For a household greater than 5 or if you live in Alaska or Hawaii, please call 866-706-2400.

4. **You have no insurance coverage or benefits for prescription medicines.**
   Pharmacy discount cards or drug company assistance programs are not insurance coverage.
5. **Our programs are primarily designed for people without prescription drug coverage. If you have prescription drug coverage but are experiencing financial hardship, you may still qualify if:**
   - You meet the income requirement noted above. Please fill out Patient Hardship Exception section on the Patient Application.

How Can I Apply?

1. **Fill out the patient sections on the Patient Application Form.**
2. **Ask your doctor to fill out the healthcare provider sections on the Patient Application Form.**
3. **Place all required documents together in a stamped envelope:**
   - ☐ Original completed and signed Patient Application Form *(both Patient and Healthcare Provider sides)*
   - ☐ Original prescription if you are applying for Lyrica® (*pregabalin*)
   - ☐ Original prescription for all medicines if you are a resident of Puerto Rico or U.S. Virgin Islands
   - ☐ Photocopies of proof-of-income documents *(please see Proof of Income section below)*

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, medicines will be dispensed at your doctor's office. Exceptions are Lyrica®, and medicines for patients residing in Puerto Rico and U.S. Virgin Islands which will be shipped to your home.

Please keep a HIPAA letter on record with each of your doctors. To obtain one, call 866-706-2400 or visit www.PfizerHelpfulAnswers.com.

What Proof of Income Do I Need to Apply?

You'll need to provide us with one of the following income documents that show your total gross annual household income:

- Current pay check stub
- Federal Tax Return (Form 1040 or 1040EZ) for the prior tax year
- 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 other forms)

If you do not have any proof of income, please call 866-706-2400 for instructions.

Pfizer reserves the right to change or cancel the Connection to Care program at any time.
Connection to Care is part of Pfizer Helpful Answers®, a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation.™

PATIENT APPLICATION

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

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 Income: $ | **Number of Persons in Household:**
(include yourself and those you are financially responsible for)

3

Do you have any insurance coverage for prescription drugs? ☐ **Yes** ☐ **No** ***(If no, skip to section #4)***

Patient Hardship Exception
If you responded yes and 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 prescription drug ☐ Medicaid ☐ Employer ☐ Other

b. **Insurance Company/Provider Name:** **Policy Number/ID:**

c. **If any of the Pfizer medicines for which you are requesting assistance are not available through your insurance plan, please provide them here.**

d. **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 my doctor has prescribed.

4

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 *Connection to Care*.
- 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 *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*.

Pfizer Patient Assistance Foundation (PPAF) understands your personal and health information is private. The information you provide will only be used by PPAF and parties acting on its behalf to send you the materials you requested and other helpful information and updates on the *Connection to Care* program.

☐ By checking this box, I also agree that Pfizer, PPAF or 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.

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

HEALTHCARE PROVIDER SECTION

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

Physician Name:			
DEA # or State License #:		**Exp. Date:**	___/___/___
Office / Ship-to Address:		**Suite #:**	
City:	**State:**	**Zip Code:**	
Office Telephone: (____) ____ – ____		**Office Fax:** (____) ____ – ____	
E-Mail Address *(optional)*:			
For all medications sent to your office, please advise any delivery restrictions here:			

Product Information

Healthcare Provider should complete this section for all products for U.S. residents. For all controlled substances *[e.g. Lyrica® (pregablin)]* and patients residing in Puerto Rico and U.S. Virgin Islands, you MUST attach your original prescription pad sheet.

Patient Name: ______ **Date:** ______

Patient Address: ______ **D.O.B.:** ___/___/___

Product Name:	**Strength:**	**Qty:**	**Dose:**

Healthcare Provider Signature: ______

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

For Lyrica® and patients residing in Puerto Rico and U.S. Virgin Islands ONLY
Complete the following and attach original prescription to this sheet.

Allergies: ☐ No Known Allergy ☐ Penicillin Allergy ☐ Aspirin Allergy ☐ Sulfa Allergy ☐ Other Allergy

Health Conditions: ☐ Diabetes ☐ Epilepsy ☐ Heart Condition ☐ Glaucoma ☐ High Blood Pressure ☐ Thyroid ☐ Ulcer ☐ Other Conditions

Prescription and over-the-counter medications: ______

NOTE: Expedited enrollment is available for the below noted products for the first fill of a new Connection to Care patient:

- **Geodon®** (ziprasidone HCl)
- **Tikosyn®** (dofetilide) *(registered prescribers only)*
- **Inspra®** (eplerenone)
- **Zithromax®** (azithromycin)

Please call 866-706-2400 for expedited handling and enrollment instructions.

By signing below, you, the healthcare provider, 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 Healthcare Providers.
- 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 a patient is applying for a Hardship Exception, 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.

Original Signature of Healthcare Provider:	X	**Date:**

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