Hardship Exception Request Form

If you have prescription coverage and are facing significant financial or medical hardship, you may still be eligible to receive prescription assistance through Pfizer *Connection to Care*® through the end of the calendar year. You and your physician will need to complete this form. Then send this form, your original application, your income verification documents and your Pfizer prescription(s) to:

Pfizer Connection to Care Program
PO Box 66585
St. Louis, MO 63166-6585

PATIENT INFORMATION:

Patient name			
Patient address		**Apartment**	
	City	**State**	**Zip Code**
Telephone number	☐☐☐ ☐☐☐ ☐☐☐☐		
Date of birth	M M / D D / Y Y Y Y	**Social Security Number**	☐☐☐ ☐☐ ☐☐☐☐

Type of prescription coverage you have:

☐ Medicare prescription drug coverage

☐ Medicaid

☐ Employer

☐ Other ______________________________

Plan information:

Insurance Provider: ______________________

Policy ID: ______________________________

Please answer the following questions:

1. Are all of the Pfizer medicines for which you are requesting assistance included on your insurance plan's formulary (the list of drugs available through your plan)? Yes ☐ No ☐

   If you checked no, please list which medicines are on the formulary.

   ____

2. Does your insurance plan have limits on the number of prescriptions you may fill? Yes ☐ No ☐
3. Does your insurance plan have limits on the dollar amount it will cover annually for prescription medicines? Yes ☐ No ☐
4. How much have you spent out of your own pocket on prescription medicines this year? $____________
5. How many prescription medicines do you take per month? 0-2 ☐ 3-5 ☐ more than 5 ☐

Please complete and sign the reverse side of this form.

PATIENT INFORMATION (CONTINUED):

Patient Declaration of Hardship

By checking one of the boxes below, I certify that I am experiencing significant financial or medical hardship. I further certify that because of this hardship, I am currently unable to pay for the Pfizer medicine my doctor has prescribed.

Please check the box that best describes your situation:

- ☐ My insurance benefits for prescription medicines have been exhausted. I am currently unable to pay for the Pfizer medicine my doctor has prescribed.
- ☐ I have already spent a significant portion of my annual income on my prescription medicines. I am currently unable to pay for the Pfizer medicine my doctor has prescribed.
- ☐ I have high medical expenses. I am currently unable to pay for the Pfizer medicine my doctor has prescribed.

Patient Attestation and Signature/Date

I understand and agree that the information I have provided is true and accurate. Pfizer may verify the accuracy of the information I have provided. I understand that completing this exception form does not ensure that I will qualify for *Connection to Care*. I certify and attest that if I receive medicine(s) through this program, I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider and that I will notify my insurance provider of any medicines I receive through *Connection to Care*. If I am a member of a Medicare prescription drug plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket expenses for prescription drugs. If my status changes, I will contact *Connection to Care*.

Patient Signature X **Date**

PHYSICIAN INFORMATION:

Name and professional designation

DEA # (if none available, state license #) **Expiration Date**

Telephone number ☐☐☐ ☐☐☐ ☐☐☐☐

Physician Attestation and Signature/Date

I certify that this prescription medication is medically indicated for this patient. 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 reason(s) the patient has indicated above.

Physician Signature X **Date**