Pfizer RxPathways™ Vaccine Replacement Program: ENROLLMENT FORM FOR GROUP C MEDICINES

Pfizer RxPathways Vaccine Replacement Program is a product replacement-based assistance program that provides eligible patients with the Prevnar 13 vaccine for free through their doctor's office. Through this program, prescribers' purchased stock of the Prevnar 13 vaccine is replenished when administered to patients approved for assistance through *Pfizer RxPathways*.

To access replacement of Prevnar 13, **prescribers** must read and complete the following steps:

STEP 1: Confirm patient eligibility

To be eligible for assistance, patients must:

- ☐ **Be at least 19 years of age**
- ☐ **Have no insurance or prescription coverage for Prevnar 13**
- ☐ **Reside in the United States**
- ☐ **Meet certain income limits:**

No. of People in your Household	Total Monthly Income Before Taxes	Total Annual Income Before Taxes
1 person	Less Than or Equal to $3,923	Less Than or Equal to $47,080
2 people	Less Than or Equal to $5,310	Less Than or Equal to $63,720
3 people	Less Than or Equal to $6,697	Less Than or Equal to $80,360
4 people	Less Than or Equal to $8,083	Less Than or Equal to $97,000
5 people	Less Than or Equal to $9,470	Less Than or Equal to $113,640

For patients who live in Alaska or Hawaii, or have a household greater than 5, please call 866-706-2400

STEP 2: Call *Pfizer RxPathways* at 1-866-706-2400 to obtain a vaccine replacement approval

Upon confirming your patient's eligibility with a *Pfizer RxPathways* representative over the phone, you will be provided with a vaccine replacement approval number.

Please note: Prescribers must verify their patient's eligibility and obtain a unique vaccine replacement approval number from Pfizer RxPathways over the phone before they can submit a completed application, or administer their own purchased stock of the Prevnar 13 vaccine to their patient in need. The approval number given is based on the information provided over the phone, and it does not guarantee vaccine replenishment. A completed application, indicating that a patient meets all eligibility requirements, must be received via fax within 30 days in order for replenishment to officially be processed.

STEP 3: Complete the application and fax it to 1-866-470-1748

Within 30 days of receiving a vaccine replacement approval #, please complete the application on the opposite side of this form with your patient and fax it to *Pfizer RxPathways* at 1-866-470-1748.

Pfizer reserves the right to change or cancel the *Pfizer RxPathways* program at any time.
Pfizer RxPathways is a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation.™

Enrollment Form for Group C Medicines:
PATIENT SECTION

Patient Name:		**Gender:** ☐ Male ☐ Female
Patient Address:		
City:	**State:**	**Zip Code:**
Telephone: (_____) _____ – _____	**E-Mail:**	
Are you 19 years of age or older? ☐ Yes ☐ No	**Date of Birth: (MM/DD/YY):** ____ / ____ / ____	

Do you have insurance or prescription coverage for Prevnar 13? ☐ Yes ☐ No

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.*

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 *Pfizer RxPathways*™ programs, products and services, to communicate with you about your experience with *Pfizer RxPathways*, and/or to send you materials and other helpful information and updates relating to *Pfizer RxPathways* programs. By signing below, I affirm that I meet the eligibility criteria for the *Pfizer RxPathways Vaccine Replacement Program* and that the information provided on this application is complete and accurate.

I understand that:

- Completing this application form does not guarantee that I will qualify for assistance with Prevnar 13 through *Pfizer RxPathways*.
- Pfizer may verify the accuracy of the information I have provided and may ask for additional information to confirm my eligibility.
- Pfizer reserves the right to change or cancel the *Pfizer RxPathways for Prevnar 13* program at any time.
- Any vaccine supplied by *Pfizer RxPathways* shall not be sold, traded, bartered, or transferred.
- The support provided through this program is not contingent upon any future purchase.

I certify and attest that if I receive the Prevnar 13 vaccine through Pfizer RxPathways:

- I will not seek reimbursement or credit for this vaccine from any insurer, health maintenance organization, or government program.
- I have completed and signed a HIPAA Authorization Form and submitted it to my Prescriber.

Patient Signature	**X**	**Date:**

Enrollment Form for Group C Medicines:
PRESCRIBER SECTION

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

VACCINE INFORMATION ***(To be completed after patient eligibility is confirmed over the phone by a PRxP Representative)***

***Pfizer RxPathways* Vaccine Replacement Approval #:** _____

Vaccine Lot #: _____ **Date of Administration:** _____

You must provide the lot number of the vaccine administered from your commercial stock, as well as the date of its administration, in order for replacement product to be provided by Pfizer RxPathways.

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 Pfizer RxPathways programs, products, and services, to communicate with you about your experience with Pfizer RxPathways, and/or to send you materials and other helpful information and updates relating to Pfizer RxPathways.

I understand that:

- My patient must meet the *Pfizer RxPathwaysVaccine Replacement Program* eligibility criteria in order to qualify for assistance.
- The product I receive is not a sample, but a replacement of product I previously purchased.
- Any vaccine ultimately supplied by Pfizer through the *Pfizer RxPathwaysVaccine Replacement Program*is for the sole use of the patient specified; it cannot be sold, traded, bartered, transferred, returned for credit, or submitted to any third party, such as Medicare or Medicaid, for reimbursement.
- Pfizer must receive a signed and completed application within 30 days in order to replenish the vaccine.
- The information provided on this application is subject to random audits and verification.
- Pfizer may change or cancel this program at any time.

I certify and attest that:

- I have obtained all necessary authorizations from my patient to release personal and health information to Pfizer Inc, the Pfizer Patient Assistance Foundation, and any third parties acting on their behalf.
- I will neither charge my patient for the Prevnar 13 vaccine, nor for its administration, if my patient is approved for assistance through *Pfizer RxPathways*.

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

Save File Print File

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 RxPathways® 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.