Reset Fields

New Patient Application

CONNECTION TO CARE™
PATIENT ASSISTANCE PROGRAM

READ THE INSTRUCTIONS ON THE OTHER SIDE FIRST. PLEASE PRINT CLEARLY IN THE SHADED AREAS. MAIL THE ORIGINAL APPLICATION TO THE ADDRESS BELOW.

PATIENT INFORMATION

Patient name

Patient address Apartment

City State Zip

Telephone number

Date of birth (month/day/year) / / Social Security number or Federal ID number

Gender Male ☐ Female ☐ Ethnic origin *(optional)* Asian ☐ Black ☐ Hispanic ☐ White ☐ Other ☐

Are you in any benefit program that helps pay for prescription drugs? Yes ☐ No ☐
SEE THE OTHER SIDE FOR EXAMPLES. IF YES, YOU CANNOT RECEIVE MEDICATION FROM THIS PROGRAM.

Are you enrolled in Medicare? Yes ☐ No ☐

Are you enrolled in a Medicare prescription drug coverage program (also known as "Part D")? Yes ☐ No ☐

Did you file a Federal tax return for the most recent tax year? Yes ☐ No ☐
IF NO, YOU MUST SIGN BOTH THE PATIENT INFORMATION SECTION AND THE REQUEST FOR IRS VERIFICATION BELOW.

Total yearly income for your entire household $

Number of dependents in your household
(INCLUDING YOURSELF AND YOUR SPOUSE IF MARRIED)

PFIZER MAY CHECK THE INFORMATION ON YOUR APPLICATION. WE MAY ASK YOU FOR MORE FINANCIAL AND INSURANCE INFORMATION. PFIZER RESERVES THE RIGHT TO CHANGE OR CANCEL THE *CONNECTION TO CARE* PROGRAM AT ANY TIME.

By signing below, I affirm that my answers, and my proof-of-income documents, are complete and accurate to the best of my knowledge.

Original patient signature for application X Date

May Pfizer use your information to contact you about your experience with the *Connection to Care* program? Yes ☐ No ☐

REQUEST FOR IRS VERIFICATION THAT YOU DID NOT FILE A TAX RETURN

If you did not file a Federal tax return for tax year 200_, sign again below in this section to agree that:

- You are asking the IRS to send confirmation to Pfizer that you did not file a Federal tax return for the tax year 200_.
- The IRS does not control how Pfizer uses this information.
- The IRS may call you to make sure you want to share this confirmation.

IRS: PLEASE SEND VERIFICATION TO
Pfizer Connection to Care
PO Box 66557
St. Louis, MO 63166-6557

Patient signature for IRS request X Date

HEALTHCARE PROVIDER TO BE COMPLETED BY THE PRACTITIONER WHO WRITES THE PRESCRIPTION

Name and professional designation of healthcare provider

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

Name of clinic or hospital *(if applicable)*

Name and title of office contact person

Shipping address *(We cannot accept a PO Box)* Suite

Telephone Fax

City State Zip

By signing below, you the healthcare provider understand and agree that:

- 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.

Original signature of practitioner X Date

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