

WYETH PHARMACEUTICAL ASSISTANCE FOUNDATION Refill Form

PLEASE PRINT and COMPLETE BOTH SIDES

STEP 3

Tell us where to ship your medications. Please fill this section out completely! Your medication order may be shipped to your health care provider's office or your home.

		DATE			
NAME					
LAST		FIRST		MI	
PATIENT'S SOCIAL SECURITY NUMBER				DAYTIME PHONE ()	
STREET MAILING ADDRESS				HOME PHONE ()	
APT. NO.		HEALTH CARE PROVIDER'S NAME			
CITY		STATE		ZIP CODE	
				HEALTH CARE PROVIDER'S PHONE ()	

I acknowledge that the information on this form is true and correct. I certify I do not have the ability to pay for my medication, earn less than 200% of the current HHS Poverty Guidelines, am a U.S. resident, and that I have no government or private insurance to pay for my medication. I consent to the release by my health care providers of my medical information pertaining to prescriptions for the Wyeth Pharmaceutical Assistance Foundation to be used for program authorization purposes.

Your Signature: X

Date:

DETACH RETURN ENVELOPE ALONG THIS PERFORATION

Complete both sides of form

BRMLWP101
07072005

PLACE
STAMP
HERE

PLEASE CHECK FOR CHANGE OF ADDRESS



SPECIALTY DISTRIBUTION SERVICES
A Subsidiary of Express Scripts

ATTN: WYT

Specialty Distribution Services
PO BOX 66762
ST. LOUIS, MO 63166-6762

WYETH PHARMACEUTICAL ASSISTANCE FOUNDATION Refill Form

PLEASE PRINT and COMPLETE BOTH SIDES

STEP 1

Complete this section every time that you place a request for medications. Include names of all medications you are taking in the comments section for a review of potential medication interactions. Include additional information on a separate sheet of paper.

PATIENT'S SOCIAL SECURITY NUMBER

				-							
--	--	--	--	---	--	--	--	--	--	--	--

NAME LAST

FIRST

MI

Rx Number: _____
Product: _____

Rx Number: _____
Product: _____

ALLERGIES

Please mark an "X" in the appropriate box for any allergies you have. If allergy is not listed here, please note below.

NO KNOWN ALLERGIES

ACETAMINOPHEN
(TYLENOL)

ASPIRIN

ERYTHROMYCIN

PENICILLIN

SULFONAMIDE DERIVATIVES
(GANTRISIN, GANTANOL, ETC.)

ALCOHOL

CEPHALOSPORIN ANTIBIOTICS
(KEFLEX, DURICEF, ETC.)

LOCAL ANESTHETICS

PROPOXYPHENE
(DARVON, DARVOCET, ETC.)

TETRACYCLINES

AMPICILLIN

CODEINE

MORPHINE AND
DERIVATIVES

SULFA

OTHER ALLERGIES

COMMENTS

Please list all medications you are currently taking, including over-the-counter medications, for review of potential medication interactions. If you need more space, please use a separate sheet of paper.

STEP 2

To request the medications approved for you by the Wyeth Pharmaceutical Assistance Foundation, complete this Refill Form and enclose your original written prescription or provide your Rx number above. Your Rx number is found on your medication label in the top left corner. A new prescription may not be required if your prescription label indicates refills are available. The number of refills remaining is indicated at the bottom of your prescription label.

(RETURN THIS PORTION)

① SLIDE FINGER UNDER GLUE SPOTS AT ENVELOPE OPEN-

↑ DETACH RETURN ENVELOPE ALONG THIS PERFORATION ↓

② COMPLETE BOTH SIDES OF FORM. SECTIONS 1-3

③ MOISTEN AND FOLD FLAP TO SEAL

IMPORTANT: PLEASE READ

IMPORTANT INFORMATION

- 1 . To be eligible for the Wyeth Pharmaceutical Assistance Foundation, you must have completed and submitted an Application Form within the past 12 months. If you have not applied to the program within the past 12 months, call **800-568-9938**.
- 2 . To avoid delay, please make sure that this refill form is filled out **completely** and **accurately**.
- 3 . If you do not receive your order within 14 days or if you have any questions, please contact us at **800-568-9938**.

CUSTOMER SERVICE 800-568-9938