Pfizer Connection to Care application

Read the instructions below. If this program is right for you…

Complete the patient section on the back, and have your healthcare provider complete their section.

Send us your original prescription form, completed and signed application form, and copies of your proof of income. If approved, we'll send up to a three-month supply of the Pfizer prescription medicine to your healthcare provider.

Pfizer Rx
CONNECTION TO CARE™
PATIENT ASSISTANCE PROGRAM

Who can apply

You can apply for medications through Connection to Care if:

- If you are single and your total household income is $19,000 or ***less*** per year. If you are married or have dependents, you can apply if the total income for you and your spouse is $31,000 or ***less*** per year, and
- You do **not** have any insurance or receive any benefits that help pay for prescription drugs, such as:
  - Medicaid
  - State-sponsored prescription drug assistance programs
  - Employee, military, retirement or pension program drug coverage.

  If you receive this kind of benefit, you cannot get medications from the Connection to Care program, even if your benefit program limits medications or does not pay the full cost.

  Pharmacy discount cards or drug company assistance programs are not insurance coverage. If you participate in these programs, you may still apply.

If your application is approved, we send up to a three-month supply of medication to your healthcare provider.

Applying for refills or additional medications

You must apply every time you request medications from the Connection to Care program, even to receive a refill of a medication you have already been taking. If you apply for a refill, send in your application before you run out, so you can continue your medication while we process your application.

You only need to submit your proof of income once per year.

What you need to send us

1 **Your original prescription form** signed by your healthcare provider.

2 **This application form** filled out and signed by both you and your healthcare provider.

3 **Proof of income** if you are applying for the first time or it has been more than 10 months since the last time you provided proof of income to us.

Proof of income includes **copies** of both:

a Your federal tax return (Form 1040 or 1040EZ) for the tax year 2003, and

b All other recent documents that show income paid to you (or your spouse if you are married), such as:
- 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-DIV, 1099 or other forms)

If you did not file a federal tax return, you must include copies of all other proof-of-income documents that you have, and complete and sign the *Request for IRS verification* section on the other side.

If you cannot provide any proof-of-income documents, call us at 1-800-707-8990 for more instructions.

Privacy Statement. Pfizer Inc respects your right to have personal and medical information kept confidential. Pfizer and companies working with Pfizer will use the information you provide to determine your eligibility and to administer the Connection to Care program. Your information will not be shared with any other third parties (such as outside mailing lists). Pfizer may use non-identifiable information (such as your gender, location or age) to evaluate the Connection to Care program or to develop other programs and services.

Put all the necessary documents together in one stamped envelope. Mail it to:

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

If you need help with your application, call **1-800-707-8990.**

Pfizer prescription medicines available through the Connection to Care Program

Accupril® quinapril HCl
Accuretic™ quinapril HCl/hydrochlorothiazide
Antivert® meclizine HCl
Arthrotec® diclofenac sodium and misoprostol
Caduet® amlodipine besylate/atorvastatin calcium
Cardura® doxazosin mesylate
Celebrex® celecoxib
Cortef® hydrocortisone
Covera-HS® verapamil hydrochloride
Cytotec® misoprostol
Detrol® tolterodine tartrate
Detrol LA® tolterodine tartrate extended release
Diabinese® chlorpropamide
Diflucan® fluconazole
Dilantin® phenytoin
Dostinex® cabergoline
Feldene® piroxicam
Glucotrol® glipizide
Glucotrol XL® glipizide extended release
Glyset® miglitol
Lipitor® atorvastatin calcium
Minipress® prazosin HCl
Minizide® prazosin polythiazide
Navane® thiothixene
Neurontin® gabapentin
Nicotrol® Inhaler (nicotine inhalation system)
Nicotrol® NS (nicotine nasal spray)
Norvasc® amlodipine besylate
Procardia® nifedipine
Procardia XL® nifedipine extended release
Relpax® eletriptan HBr
Sinequan® doxepin HCl
Viagra® sildenafil citrate
Vibramycin® doxycycline hyclate
Vistaril® hydroxyzine pamoate
Xalatan® latanoprost
Zarontin® ethosuximide
Zoloft® sertraline HCl
Zyrtec®† cetirizine HCl

For additional products, please call **1-800-707-8990**

† ZYRTEC is a registered trademark of UCB Pharma, Inc.

Pfizer Connection to Care application

Patient section Read the instructions on the other side first. Please print clearly in the shaded areas.

Your name

Your address Apartment

City State Zip Code

Telephone number: Best time to call you:

Date of birth: m m / d d / y y y y **Social Security Number:**

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

Are you enrolled in Medicare? Yes ☐ No ☐

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 medicine from this program.

Number of dependents in your household: (including yourself) **Are you married?** Yes ☐ No ☐

If you are single, is your total yearly household income **less than $19,000**, or Yes ☐ No ☐
If you are married or have dependents, is your total yearly household income **less than $31,000?**
See the other side for more information.

Did you file a Federal tax return for the most recent tax year? Yes ☐ No ☐
If No, you must sign both the Patient Section and the **Request for IRS verification** below.

Total yearly income for your entire household: $

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.

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 2003, 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 2003.
- 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: send verification to:
Pfizer Connection to Care
PO Box 66557
St Louis, MO 63166-6557

Patient signature for IRS request X **Date**

Healthcare Provider section To be completed by the practitioner who writes the prescription.

Name and professional designation of healthcare provider

DEA # Expiration Date

State License # *If no DEA # available* Expiration Date

Name of clinic or hospital *If applicable*

Name and title of office contact person

Telephone Fax

Mailing address *for correspondence* Suite

City State Zip

Shipping address *We cannot accept a P.O. Box* Suite

City State Zip

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

- To the best of your knowledge, the patient named on this application meets Pfizer's eligibility requirements for this program.
- Any medications supplied by Pfizer as a result of this application 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 Date

X

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