Wyeth Pharmaceutical Assistance Foundation
P.O. Box 66762
St. Louis, MO 63166-6762

Dear Patient or Health Care Practitioner:

Thank you for your interest in the Wyeth Pharmaceutical Assistance Foundation Patient Assistance Program. To be eligible for the Patient Assistance Program, **a patient must be a U.S. or Puerto Rico resident, must meet income requirements, and must not have prescription drug coverage from a private insurer or government health program, including Medicare and Medicaid**. To avoid delay, please use the enclosed application. Complete the following steps to apply for the Patient Assistance Program:

1. Complete all patient and licensed prescriber sections of the attached application; both patient and licensed prescriber must sign the application.
2. Patient must sign attached authorization form and give to health care provider.
3. Please include a prescription.
4. Mail the application and prescription to:

WYETH PHARMACEUTICAL ASSISTANCE FOUNDATION
PATIENT ASSISTANCE PROGRAM
P.O. BOX 66762
ST. LOUIS, MO 63166-6762

PRODUCTS PROVIDED BY THE WYETH PHARMACEUTICAL ASSISTANCE FOUNDATION PATIENT ASSISTANCE PROGRAM

Cordarone® (amiodarone HCl) Tablets 200mg

Effexor® (venlafaxine HCl) Tablets 25mg, 37.5mg, 50mg, 75mg, & 100mg

Effexor XR® (venlafaxine HCl) Extended-Release Capsules 37.5mg, 75mg, & 150mg

Inderal® (propranolol HCl) Tablets 10mg, 20mg, 40mg, 60mg, & 80mg

Inderal® LA (propranolol HCl) Long-Acting Capsules 60mg, 80mg, 120mg, & 160mg

Inderide® (propranolol HCl and hydrochlorothiazide) Tablets 40/25mg

Phospholine Iodide (echothiophate iodide) 6.25mg per 5ml

Premarin® (conjugated estrogens tablets, USP) 0.3mg, 0.45mg, 0.625mg, 0.9mg, & 1.25mg

Premarin® (conjugated estrogens) Vaginal Cream 0.625mg

Premphase® (conjugated estrogens/medroxyprogesterone acetate tablets) 0.625/5mg

Prempro™ (conjugated estrogens/medroxyprogesterone acetate tablets) 0.3/1.5mg, 0.45/1.5mg, 0.625/2.5mg, & 0.625/5mg

Protonix® (pantoprazole sodium) Tablets 40mg

Trecator® (ethionamide tablets, USP) 250 mg

Medications available through the Patient Assistance Program are subject to change at any time.

We will review and process the patient's eligibility once the completed application and prescription are received. You will receive written notification concerning the patient's eligibility within 5 to 7 business days.

If you have questions, please call a Wyeth Pharmaceutical Assistance Foundation representative at 1-866-590-5885, Monday through Friday, 8:00 am to 5:00 pm CST.

Sincerely,

Wyeth Pharmaceutical Assistance Foundation
Patient Assistance Program

Wyeth Pharmaceutical Assistance Foundation
P.O. Box 66762
St. Louis, MO 63166-6762
Questions: Call 1-800-568-9938

Wyeth

Patient assistance application

Please attach written prescription
All items must be completed

Section 1 – Licensed Prescriber			
Licensed Prescriber Name:	State License #:	Phone: ( ) Fax: ( )	
Address:	City:	State:	Zip:

Section 2 - Medication Information

Medication should be sent to: Licensed Prescriber's office ☐ Patient's address ☐ (Phospholine Iodide must be sent to Licensed Prescriber)

Is the patient allergic to medications? No ☐ Yes ☐ Please list all:

List all medications the patient is currently taking:

Licensed Prescriber Attestation: I request the medication to be provided to me for the following patient who certified that he/she is a U.S. Resident earning less than 200% of the current HHS Poverty Guidelines and is not eligible for any third-party payment (Medicaid, Insurance, Government Agencies) for the medication requested. I agree that if this application is approved, the medication will be provided to the patient identified below free of charge, i.e., neither the patient nor any third party will be billed for the medication. I have obtained and maintain a valid HIPAA Authorization form from the following patient pertaining specifically to the Wyeth Patient Assistance Program.

Licensed Prescriber Signature: **X**	Date:

Section 3 - Patient Information			
Patient Name:		Social Security, Green Card or Visa Number: - -	
Street Address:		Date of Birth: / /	Male ☐ Female ☐
City	State	Zip	Phone: ( )

Section 4 – Enrollment Information			
Number of Household members (including self) **(circle one)** 1 2 3 4 5 6 7 other	U.S. Resident Yes ☐ No ☐	Are you a Veteran of the U.S. Armed Forces? Yes ☐ No ☐	Are you Disabled? Yes ☐ No ☐

List All Sources, Gross Monthly Amounts

Salary/Wages $_____ Social Security $_____

Social Security Disability $_____ Pension/Retirement $_____

Child Support/Alimony $_____ Unemployment/Work Comp $_____

Total Gross Household Income Monthly: _____

Prescription Drug Coverage		
Prescription Drug Coverage: Private / Commercial Insurance	Yes ☐	No ☐
Medicaid Drug Coverage	Yes ☐	No ☐
Medicare Drug Coverage / Medicare Part D	Yes ☐	No ☐
State Elderly Drug Assistance	Yes ☐	No ☐

Total Patient Assets: $_____(This includes savings/checking, IRA, annuities, stocks/bonds/CDs)

Section 5 – Patient Signature

I authorize Wyeth Pharmaceuticals and the Wyeth Pharmaceutical Assistance Foundation to use this information to assess my eligibility for participation in the Patient Assistance Program ("Program"), including the audit of my medical records and/or by contacting me directly to confirm my eligibility or receipt of drug and matters related to such program. I understand that this assistance is temporary and that this Program may be discontinued or changed at any time. I understand that Wyeth Pharmaceuticals and the Wyeth Pharmaceutical Assistance Foundation will use my personal information in connection with the operation of the Program and issues related to such program. 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 also certify that I do not have other sufficient financial resources or assets to pay for the medication requested or that paying for the medication from my own resources or assets would cause me severe financial hardship. I attest the information I have provided is correct and complete.

I authorize the Supplier of the Program to disclose to Wyeth Pharmaceuticals and the Wyeth Pharmaceutical Assistance Foundation all personal information relating to my medical condition, treatment and insurance coverage needed to administer my participation in the Program. I understand that if I refuse to sign this authorization, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment or affect my insurance enrollment or eligibility for insurance benefits. I understand that I may cancel this authorization at any time by mailing a letter to the Program. Canceling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed but will not affect disclosures made before that time. I understand that once my personal information is disclosed to Wyeth Pharmaceuticals and the Wyeth Pharmaceutical Assistance Foundation, federal privacy laws may no longer protect the information from further disclosure. This authorization expires at the end of my participation in the Program.

Patient's or Legal Guardian's Signature: **X**	Date:

Wyeth Patient Assistance Program Authorization Form

Wyeth

This Patient Assistance Program Authorization Form authorizes your health care provider to disclose your health and medical information to Wyeth and to the Wyeth Pharmaceutical Assistance Foundation and their respective employees, representatives and agents or its suppliers (collectively, "**Wyeth**") in connection with your application to the Wyeth Patient Assistance Program (the "**Wyeth PAP**") as required by the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("**HIPAA**").

Authorization.

I, _____ **[First, Middle and Last Name]**, hereby authorize _____ **[Name of Physician or Medical Group]** ("**Health Care Provider**") to disclose my individually identifiable health and medical information described below to Wyeth solely for the authorized purposes described in this authorization form.

Description of Health and Medical Information That May Be Disclosed.

My Health Care Provider may disclose individually identifiable health and other information that supports my application to the Wyeth PAP and that may include my name, address, date of birth, social security number, financial information, medical records and the specialty of my health care provider.

Authorized Purposes.

The authorized purposes are: (1) to permit Wyeth to evaluate my eligibility for participation in the Wyeth PAP; and (2) if Wyeth, in its sole discretion, approves my request to participate, for Wyeth's administration of my participation in the Wyeth PAP.

Expiration of Authorization.

My authorization shall expire (1) when Wyeth does not approve my application for participation in Wyeth's PAP, or (2) at the conclusion of my participation in the Wyeth PAP, whichever is earlier.

Acknowledgments.

(1) I understand that Wyeth is not an entity covered by HIPAA and related federal privacy regulations and that my medical and health information may be subject to redisclosure by Wyeth and no longer protected by such federal privacy regulations. I further understand and agree that Wyeth may retain my medical and health information as disclosed to Wyeth by my Health Care Provider under this authorization after this authorization expires for purposes related to the administration of the Wyeth PAP.

(2) I understand that I may refuse to sign this authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my Health Care Provider; or to seek payment or my eligibility for benefits. However, I understand that I may not participate in the Wyeth PAP if I refuse to sign this authorization form.

(3) I understand that I may revoke my authorization at any time by providing a written notice of same to my Health Care Provider that refers to (or with a copy of) this authorization form, or as set forth in my Health Care Provider's Notice of Privacy Practices (if any). However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my Health Care Provider to Wyeth in reliance on this authorization.

_____ _____

Signature of Patient or Patient's Personal Representative Date

_____

Patient's Name

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

HEALTH CARE PROVIDER MUST GIVE PATIENT AND/OR PATIENT'S REPRESENTATIVE A SIGNED COPY

Health Care Provider has verified Patient Representative's authority to act on Patient's behalf _____ (check)