

# ENROLLMENT FORM: PATIENT APPLICATION

Please complete the form where applicable and return via mail or fax.



Phone 1-877-744-5675 or Fax 1-800-708-3430

PO Box 220582, Charlotte, NC 28222-0582

Please check the appropriate Pfizer product:

<input type="checkbox"/> Sutent® ( <i>sunitinib malate</i> ) capsules	<input type="checkbox"/> Aromasin® ( <i>exemestane</i> ) tablets
<input type="checkbox"/> Emcyt® ( <i>estramustine phosphate sodium</i> ) capsules	<input type="checkbox"/> Xalkori® ( <i>crizotinib</i> ) capsules

**SUTENT PATIENT SUPPORT PROGRAM**

By checking this box, you would like to receive more info about the free Sutent Patient Call Center to help supplement the info you receive from your health care provider about Sutent and provide you an added support resource while on treatment.

Patient Name:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Address:		E-mail:
City:	State:	Zip Code:
Telephone (Day): (____) ____ - ____	(Evening): (____) ____ - ____	
Date of Birth (DOB): ____/____/____	U.S./Puerto Rico/U.S.V.I. Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**INSURANCE INFORMATION (Include all insurance policies)**

Do you have insurance?  Yes  No *(If yes, complete the information below or attach a photocopy of insurance card)*

Primary Insurance Co. Name:	Phone #: (____) ____ - ____
Policy Holder Name:	Policy Holder DOB: ____/____/____
Policy Holder SSN: ____-____-____	Policy #: _____ Group #: _____
Prescription Card Name:	Phone #: (____) ____ - ____
Policy #:	Group #:
Secondary Insurance Co. Name:	Phone #: (____) ____ - ____
Policy Holder Name:	Policy Holder DOB: ____/____/____
Policy Holder SSN: ____-____-____	Policy #: _____ Group #: _____
Prescription Card Name:	Phone #: (____) ____ - ____
Policy #:	Group #:

**PATIENT FINANCIAL INFORMATION**

Total Number of People Within Household (including applicant): \_\_\_\_\_

Total Annual Income for Entire Household: \$ \_\_\_\_\_ *(The current annual household income includes current annual salary, Social Security, unemployment insurance benefits and workers' compensation)*

Please submit documentation to support the financial information

Attached is:  Most recent federal tax return (1040 form)  W-2 form  Other

We must receive proof of income to determine eligibility for assistance.

If you are required to file a federal tax return, please provide a signed copy. Proof of income may include documents such as: copy of most recent federal tax return, W-2 form(s), 1099 form, Social Security Award Letter or Check, or copy of three most recent pay stubs.

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

**I understand that:**

- Completing this application form does not guarantee that I will qualify for the First Resource Program.
- Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medications supplied with the First Resource Program shall not be sold, traded, bartered or transferred.
- Pfizer reserves the right to change or cancel the First Resource Program at any time.
- The support provided in this program is not contingent on any future purchase.

**I certify and attest that if I receive medicine(s) provided by Pfizer through the First Resource Program:**

- I will promptly contact First Resource Program if my financial status or insurance coverage changes.
- I will not seek to have the medicine(s) or any cost from it (them) counted in my Medicare Part D out-of-pocket expenses for prescription drugs.
- I will not seek reimbursement or credit for any costs associated with the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans.
- I will notify my insurance provider of the receipt of any medicine(s) through the First Resource Program.

Pfizer and Pfizer Patient Assistance Foundation (PPAF) understand your personal and health information is private. The information you provide will only be used by Pfizer, PPAF and parties acting on their behalf to send you the materials you request and other helpful information and updates on the First Resource Program.

By checking this box, I also agree that Pfizer and PPAF and companies acting on their behalf may send me materials about other health conditions, use my information to develop or improve products and services, or contact me in the future about my experience with the First Resource Program or other health-related topics.

Patient Signature <i>(Parent or Guardian, if under 18 years of age)</i> X	Date:
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# ENROLLMENT FORM: HEALTHCARE PROVIDER APPLICATION

Please read all information and print clearly.



<b>PRESCRIBER INFORMATION</b> <i>(To be completed by the provider)</i>		
Prescriber Name & Title:		NPI #:
Payer Specific #:		Tax ID #:
State License #:		DEA #:
Contact Name:		
Name of Facility:		
Facility Address:		
City:	State:	Zip Code:
Phone: (____) _____ - _____	Fax: (____) _____ - _____	
Prescriber E-mail Address:		

**Please provide diagnosis and specific ICD-9 code:**

**PRESCRIBER CERTIFICATION**  
 I certify that the information provided is current, complete, and accurate to the best of my knowledge. I will notify First Resource immediately if the Pfizer product is no longer medically necessary for this patient's treatment. **I certify that the Pfizer product is medically necessary for this patient and I will be supervising the patient's treatments.** I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification and insurance information to Pfizer and their agents and representatives. I understand that any information provided is for the sole use of Pfizer and their agents and representatives to verify my patient's insurance coverage, to assess, if applicable, patient's eligibility for participation in the patient assistance program and to otherwise administer the First Resource program and related services. I understand that application to the patient assistance program does not guarantee that assistance will be obtained. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the patient assistance program, and I agree to immediately notify a First Resource representative if I become aware of changes in the patient's insurance status. I agree that First Resource may contact me for additional information relating to this application either by fax or any other form of communication, including but not limited to e-mail and telephone. I understand that I am under no obligation to prescribe any Pfizer product and that I have not received nor will I receive any benefit from Pfizer or their agents or representatives for prescribing a Pfizer product. I agree that I will not submit claims for product provided by the Patient Assistance Program  
 Pfizer and Pfizer Patient Assistance Foundation (PPAF) understand your information is private. Any information you provide will only be used by Pfizer, PPAF and parties acting on their behalf to administer the First Resource Program and to comply with applicable legal requirements.

By checking this box, I also agree that Pfizer and PPAF and companies acting on their behalf may contact me about my experience with the First Resource Program to help improve services.

Prescriber Signature:	X	Date:
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<b>PATIENT INFORMATION</b>		
First Name:	Last Name:	
Date of Birth: ____/____/____	Phone #: (____) _____ - _____	
Patient Address:		
City:	State:	Zip Code:
Shipping Address <i>(If different than above):</i>		
City:	State:	Zip Code:

<b>PRESCRIPTION</b> <i>(For full prescribing information, go to www.pfizer.com)</i>		
Directions:	Refill: _____ times	
Drug Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:		
<input type="checkbox"/> Sutent: _____ mg, 28-day supply	<input type="checkbox"/> Aromasin: 25 mg, 90 day supply	<input type="checkbox"/> Xalkori: 250 mg, 90-day supply
<input type="checkbox"/> Sutent: _____ mg, 42-day supply	<input type="checkbox"/> Emcyt: _____ mg, 90 day supply	<input type="checkbox"/> Xalkori: 200 mg, _____ day supply
Prescriber Signature:	X	Date:

Please fax completed prescription form to First Resource at (800) 708-3430. Thank You.  
 Prescription valid for one year.

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 Helpful Answers® 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.**

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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.*