

New Patient Application

READ BELOW TO SEE IF THIS PROGRAM IS RIGHT FOR YOU.



WHO CAN APPLY

You can apply for medications through *Connection to Care* if:

- o Your total family household income is at or below 200% of the Federal Poverty Level. Please see the chart on this page to see if you qualify, **and**
- o You do **not** have any insurance or receive any benefits that help pay for prescription drugs, such as:
 - o Medicaid
 - o Medicare prescription drug program (*Medicare Part D*)
 - o State-sponsored prescription drug assistance programs
 - o 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.

This program is not available to residents of Puerto Rico.

APPLYING FOR REFILLS OR ADDITIONAL MEDICATIONS

If you are already enrolled in *Connection to Care* and would like to order refills or new Pfizer products, please have your physician call 800 707 8990. If you would like a refill, please have your physician call us before you run out so you can continue your medication while we process the request. *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 prior tax year, **and**
 - b All other recent documents that show income paid to you (or your spouse if you are married), such as:
 - o Wage and tax statements (*W-2 forms*)
 - o Social Security, Pension, or Railroad Retirement statements (*SSA-1099 or similar*)
 - o Statements of interest, dividends, or other income (*1099-INT, 1099, 1099-DIV, 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 800 707 8990 for more instructions.

Place all required documents together in a stamped envelope and mail to:

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

If you need help with your application, please call 800 707 8990.

PFIZER PRESCRIPTION MEDICINES

- Accupril®** Quinapril HCl
- Accuretic™** Quinapril HCl/Hydrochlorothiazide
- Caduet®** Amlodipine Besylate/Atorvastatin Calcium
- Celebrex®** Celecoxib
- Chantix™** Varenicline
- Detrol®LA** Tolterodine Tartrate Extended Release
- Detrol®** Tolterodine Tartrate
- Diflucan®** Fluconazole
- Dilantin®** Phenytoin
- *Geodon®** Ziprasidone
- Glucotrol®** Glipizide
- Glucotrol XL®** Glipizide Extended Release
- *Inspra®** Eplerenone
- Lipitor®** Atorvastatin Calcium
- †Lyrica®** Pregabalin CV
- Neurontin®** Gabapentin
- Norvasc®** Amlodipine Besylate
- Procardia XL®** Nifedipine Extended Release
- Relpax®** Eletriptan HBr
- *Rescriptor®** Delavirdine Mesylate
- *Tikosyn®** Dofetilide
- Viagra®** Sildenafil Citrate
- *Viracept®** Nelfinavir Mesylate
- Xalatan®** Latanoprost
- *Zithromax®** Azithromycin
- Zolof®** Sertraline HCl
- ‡Zyrtec®** Cetirizine HCl

THIS IS A PARTIAL LIST OF AVAILABLE MEDICINES. FOR ADDITIONAL PFIZER MEDICINES, PLEASE CALL 800 707 8990.

2006 Federal Poverty Chart (200%)

Number of Persons in Family Household	Income
1	\$19,600
2	\$26,400
3	\$33,200
4	\$40,000
5	\$46,800

For persons in a family household greater than 5, or if you live in Alaska or Hawaii, please call 800 707 8990.

For information on the current Federal Poverty Level visit www.aspe.hhs.gov/poverty

PRIVACY STATEMENT PFIZER INC RESPECTS YOUR RIGHT TO CONFIDENTIALITY OF YOUR PERSONAL AND MEDICAL INFORMATION. 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 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.

Fill Out the **APPLICATION**
(other side)

Mail **APPLICATION** COMPLETED AND SIGNED
ORIGINAL PRESCRIPTION NO PHOTOCOPIES
PHOTOCOPIES OF PROOF-OF-INCOME DOCUMENTS

* If you are ordering this product for the first time, please call 800 707 8990.

† You must also fill out a *Lyrica* form in addition to this form. Please call 800 707 8990 to have a form mailed or faxed to you or your doctor.

‡Zyrtec is a registered trademark of UCB Pharma, Inc.



New Patient Application

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

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

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

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