

Please follow the instructions in the left-hand column and print clearly.

- To receive a supply of Lyrica, you must mail this form and an original prescription to the address below.
- If you are new to *Connection to Care*, you will need to send in a New Patient Application and financial documents along with this form.
- This form is only to receive Lyrica. For any other medicines, please call 800-707-8990.
- 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.

Please be sure to fill in all requested items.

 **Patient Information**

Patient Name _____

Patient Address _____ **Apartment** _____

City _____ State _____ Zip _____

Telephone Number - -

Date of Birth (month/day/year) / /

Social Security Number - -

Gender Male Female

 **Health History**

Please be sure of your answers when you fill out this section. If you are not sure about any of these items, talk to your doctor.

Allergies

No Known Allergy Penicillin Allergy Aspirin Allergy Sulfa Allergy

Other Allergy _____

Health Conditions

Diabetes Epilepsy Heart Condition Glaucoma

High Blood Pressure Thyroid Ulcer

Other Conditions _____

List all of your prescription and over-the-counter medicines.

Prescription and over-the-counter medicines _____

Pfizer reserves the right to change or cancel the Connection to Care program at any time. **By signing below, I affirm that my answers are complete and accurate to the best of my knowledge.** Additionally I consent to the submission of my prescription information, health history, and a copy of this application by the healthcare provider named below to any mail-order pharmacy that may dispense any medication for which I may qualify under the Connection to Care program.

You must sign here for your order to be filled.

X

Signature of patient (no photocopies or stamps) _____ **Date** _____

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 other third parties (such as outside mailing lists). Pfizer may use nonidentifiable information (such as your gender, location or age) to evaluate the *Connection to Care* program or to develop other programs and services.

Order Form

Patient Name _____

Date of Birth (month/day/year) / /

Social Security Number - -

The doctor who writes the prescription for Lyrica should fully complete this section.

▶  **Physician Information**

Name and Professional Designation of Physician		DEA # (required)	Expiration Date
Office Address (for correspondence)		Suite	Name of Clinic or Hospital (if Applicable)
City	State	Zip	Name and Title of Office Contact Person
Telephone Number		Fax Number	

By signing below, you the physician understand and agree that:

- *Connection to Care* will be shipping only Lyrica directly to the patient's home.
- Pfizer may contact the patient directly to confirm receipt of medications.
- Pfizer may change or cancel this program at any time.

The doctor **must** sign here for the order to be filled. ▶

X
Signature of physician (no photocopies or stamps) _____ Date _____

Lyrica is a controlled substance, Schedule V. State restrictions may apply.

Mail completed form and original prescription to:

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

If you have any questions, concerns, or need help with this form, please call **800-707-8990**.