ENROLLMENT FORM: PATIENT APPLICATION

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

RSVP™ A Pfizer Helpful Answers Program

Phone 1-888-327-7787 or Fax 1-888-773-0121 PO Box 220574, Charlotte, NC 28222-0574

Please check the appropriate Pfizer product:

☐ Zyvox® *(linezolid)*	☐ Xyntha® Antihemophilic Factor *(recombinant)*, Plasma/Albumin-Free
☐ Rapamune® (*sirolimus*)	☐ BeneFIX® Coagulation Factor IX *(recombinant)*
☐ Revatio® *(sildenafil)*	☐ Vfend® (*voriconazole*)
☐ Elelyso® (*taliglucerase alfa*)	☐ Tygacil® *(tigecycline)* *(Reimbursement Services Only)*

Patient Name:		Sex: ☐ Male ☐ 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: ☐ Yes ☐ 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 #:	Effective Date:	Group #:
Secondary Insurance Co. Name:	Phone #: ( ) –	
Policy Holder Name:	Policy Holder DOB: / /	
Policy Holder SSN: – –	Policy #:	Group #:
Prescription Card Name:	Phone #: ( ) –	
Policy #:	Effective Date:	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 RSVP 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 RSVP Program shall not be sold, traded, bartered or transferred.
- Pfizer reserves the right to change or cancel the RSVP 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 RSVP Program:

- I will promptly contact the RSVP 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 RSVP Program.

The information you provide will be used by Pfizer, the Pfizer Patient Assistance Foundation and parties acting on their behalf to determine eligibility, to manage and improve Pfizer Helpful Answers (PHA) programs, products and services, to communicate with you about your experience with PHA and the RSVP Program, and/or to send you materials and other helpful information and updates relating to PHA programs.

Patient Signature *(Parent or Guardian, if under 18 years of age)*	X	Date:

Printed in USA/May 2012

ENROLLMENT FORM: HEALTHCARE PROVIDER APPLICATION

Please read all information and print clearly.

RSVP
A Pfizer Helpful Answers Program

PRESCRIBER INFORMATION *(To be completed by the provider)*		
Prescriber Name & Title:		NPI #:
Payer Specific #:	Tax ID #:	
State License #:	DEA #:	
Contact Name:		
Name of Facility:		
Facility Address:		
City:	State:	Zip Code:
Ship to: ☐ Prescriber ☐ Patient ☐ Other (please provide shipping address):		
Phone: (_____) _____ – _____	Fax: (_____) _____ – _____	
Prescriber E-mail Address:	Prescriber Specialty:	
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 RSVP 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 RSVP program and related services. I understand that application to the patient assistance program does not guarantee that assistance will be obtained. I understand that Pfizer may change or cancel this program at any time. 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 RSVP representative if I become aware of changes in the patient's insurance status. I agree that RSVP 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.

The information you provide will be used by Pfizer, the Pfizer Patient Assistance Foundation and parties acting on their behalf to administer and improve Pfizer Helpful Answers (PHA) programs, products, and services, to communicate with you about your experience with PHA and the RSVP Program, and/or to send you materials and other helpful information and updates relating to PHA programs.

Prescriber Signature:	X	Date:

PRESCRIPTION *(This prescription form is not needed for Zyvox. For full prescribing information, go to www.pfizer.com)*	
First Name:	Last Name:
Date of Birth: ____/____/____	Phone #: (_____) _____ – _____
Directions:	Refills: _____ times

Drug Allergies: ☐ Yes ☐ No If yes, please specify:

☐ **Vfend:** 50 mg, 60 day supply ☐ **Rapamune:** .5 mg, 90 day supply ☐ **Rapamune:** 2 mg, 90 day supply
☐ **Vfend:** 200 mg, 60 day supply ☐ **Rapamune:** 1 mg, 90 day supply ☐ **Rapamune Oral Solution:** 1 mg
☐ **Revatio:** 20 mg, 90 day supply ☐ **Elelyso:** Total dose _____ units every _____ weeks, 28 day supply

☐ **Xyntha Antihemophilic Factor, Plasma/Albumin-Free** ☐ **BeneFIX Coagulation Factor IX**
☐ 250 IU ☐ 500 IU ☐ 1,000 IU ☐ 2,000 IU Monthly dosage: _____ IU

Prescribing Physician:

Prescriber Signature:	X	Date: ____/____/____

TRANSPLANT HISTORY *(For Rapamune Only, Complete Transplant History)*	
Transplant Type:	Date of Transplant:
Transplant Facility:	Medicare Approved Facility: ☐ Yes ☐ No

Please fax completed prescription form to RSVP at (888) 773-0121. Thank You. Prescription valid for one year.

Printed in USA/May 2012