

ENROLLMENT FORM: PATIENT APPLICATION

Please print clearly in the shaded areas on the application.
Please complete the form where applicable and return via mail or fax.



Phone 1-888-327-7787 or Fax 1-888-773-0121

PO Box 220574, Charlotte, NC 28222-0574

Please check the appropriate Pfizer product:

<input type="checkbox"/> Zyvox® (<i>linezolid</i>)	<input type="checkbox"/> Xyntha® Antihemophilic Factor (<i>recombinant</i>), Plasma/Albumin-Free
<input type="checkbox"/> Rapamune® (<i>sirolimus</i>)	<input type="checkbox"/> BeneFIX® Coagulation Factor IX (<i>recombinant</i>)
<input type="checkbox"/> Revatio® (<i>sildenafil citrate</i>)	<input type="checkbox"/> Vfend® (<i>voriconazole</i>)
	<input type="checkbox"/> Tygacil® (<i>tigecycline</i>)* <small>* Reimbursement Services Only</small>

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 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.

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



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:	
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. 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 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 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 RSVP 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 RSVP Program to help improve services.

Prescriber Signature:	X	Date:
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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: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:	
<input type="checkbox"/> Vfend: 50 mg, 60 day supply <input type="checkbox"/> Rapamune: .5 mg, 90 day supply <input type="checkbox"/> Rapamune: 2 mg, 90 day supply <input type="checkbox"/> Vfend: 200 mg, 60 day supply <input type="checkbox"/> Rapamune: 1 mg, 90 day supply <input type="checkbox"/> Rapamune Oral Solution: 1 mg <input type="checkbox"/> Revatio: 20 mg, 90 day supply	
<input type="checkbox"/> Xyntha Antihemophilic Factor, Plasma/Albumin-Free <input type="checkbox"/> BeneFIX Coagulation Factor IX <input type="checkbox"/> 250 IU <input type="checkbox"/> 500 IU <input type="checkbox"/> 1,000 IU <input type="checkbox"/> 2,000 IU Monthly dosage: _____ IU	

TRANSPLANT HISTORY *(For Rapamune Only, Complete Transplant History)*

Transplant Type:	Date of Transplant: ____/____/____
Transplant Facility:	Medicare Approved Facility: <input type="checkbox"/> Yes <input type="checkbox"/> No
Prescribing Physician:	
Prescriber Signature:	Date:

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