

ENROLLED PATIENT RE-ORDER FORM

FOR HEALTHCARE PROFESSIONAL USE ONLY



DO NOT USE THIS FORM UNLESS PATIENT HAS ALREADY BEEN APPROVED FOR THE PFIZER CONNECTION TO CARE PROGRAM

Please fill out the form below and fax to 866-470-1748
or place your order via our automated system by calling 866-706-2400.

PATIENT INFORMATION			
Patient Name: _____			
Patient Address: _____			
City: _____	State: _____	Zip Code: _____	
Telephone: (____) _____ - _____	Date of Birth: (MM/DD/YY): ____/____/____		

MEDICATION ORDER <i>(90-day Supply)</i>			
For Refills / New Orders / Change To Existing Medications, except Lyrica® (<i>pregabalin</i>).			
For all controlled substances original prescription pad MUST be used (e.g. Lyrica®). Please attach to this sheet.			
Product Name: _____	Strength: _____	Qty: _____	Dose: _____
Product Name: _____	Strength: _____	Qty: _____	Dose: _____
Product Name: _____	Strength: _____	Qty: _____	Dose: _____

FOR LYRICA® ONLY	
Complete the following and attach original prescription to this sheet.	
Allergies: <input type="checkbox"/> No Known Allergy <input type="checkbox"/> Penicillin Allergy <input type="checkbox"/> Aspirin Allergy <input type="checkbox"/> Sulfa Allergy <input type="checkbox"/> Other Allergy	
Health Conditions: <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Condition <input type="checkbox"/> Glaucoma <input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Thyroid <input type="checkbox"/> Ulcer <input type="checkbox"/> Other Conditions	
Prescription and over-the-counter medications: _____	

SHIPPING INFORMATION <i>(Physician's Shipping Address)</i>			
Physician Name: _____			
DEA # or State License #: _____			Exp. Date: ____/____
Office / Ship-to Address: _____			Suite #: _____
City: _____	State: _____	Zip Code: _____	
Office Telephone: (____) _____ - _____	Office Fax: (____) _____ - _____		
E-Mail Address <i>(optional)</i> : _____			

By signing below, you, the healthcare provider, understands and agrees to the following:

- Receive and secure patient's medication at your office until dispensed to your patient.
- Comply with and abide by my State Practitioner Dispensing Laws for authorized Healthcare Providers.
- 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.
- The medicine will be provided only to this eligible and specific enrolled patient at no charge of any kind.
- If a patient is applying for a Hardship Exception, I certify that this medication order or attached controlled substance prescription is medically indicated for this patient, and I will be supervising the patient's treatments. To the best of my knowledge, this patient would not be able to obtain this medicine without assistance from *Connection to Care* for the reasons the patient has indicated in this application.

Original Signature of Healthcare Provider:	X	Date:
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