

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 (*For full prescribing information, go to www.pfizer.com*)

Zyvox® (*linezolid*)

Vfend® (*voriconazole*)

Revatio® (*sildenafil citrate*)

Patient Name:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient Address:			
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 (Patient Assistance Program Only)
Total Number of People Within Household (including applicant): _____
Please list the current annual household income, which includes current annual salary, social security, unemployment and workers' compensation.
Total Annual Income for Entire Household: \$ _____
Attached is: W-2 form Most recent tax return Other
We must receive proof of income WITHIN 30 DAYS to determine eligibility for assistance.
Please submit documentation to support the financial information reported above. Proof of income may include documents such as: most recent tax return, W-2 form(s), Social Security Check, or copy of most recent pay stub.

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 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 Patient Assistance Foundation (PPAF) understands your personal and health information is private. The information you provide will only be used by PPAF and parties acting on its behalf to send you the materials you requested, and other helpful information and updates on the RSVP Program.

By checking this box, I also agree that Pfizer, PPAF or 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 (Parent or Guardian, if under 18 years of age)	X	Date:
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ENROLLMENT FORM: HEALTHCARE PROVIDER APPLICATION

Please read all information and print clearly in the shaded areas.



STATEMENT OF MEDICAL NECESSITY (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: (____) _____ - _____		
Physician E-Mail Address:			
Please provide Diagnosis and specific ICD-9 Code:			Dosing Regimen:
PHYSICIAN 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.			
Healthcare Provider Signature:	X		Date:

PERScription INFORMATION <i>All products (except Zyvox) will be shipped to the prescriber's office. If alternate shipping arrangements are needed, please contact the RSVP program at 1-888-327-7787.</i>	
First Name:	Last Name:
Date of Birth: ____/____/____	Phone #: (____) _____ - _____
PRESCRIPTION (Please complete the following prescription if requesting Revatio, Vfend, Rescriptor, Selzentry or Viracept. This prescription form is not needed for Zyvox.)	
Directions:	
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"/> Revatio: 20 mg, 90 day supply
<input type="checkbox"/> Vfend: 200 mg, 60 day supply	
Prescribing Physician:	
Physician Signature:	Date:
X	
Please fax completed prescription form to RSVP at (888) 773-0121. Thank You. Prescription valid for one year.	