



Program Criteria:

1. You reside in the United States AND became unemployed starting on or after January 1, 2009.
2. You are currently taking a Pfizer medicine and have been for at least 3 months prior to your unemployment and enrollment in program.
3. You have no insurance coverage or benefits for prescription medicines.
4. You are unable to pay for your medicines without this program.
5. You have proof of unemployment. Examples include: State Unemployment Benefits Confirmation Letter, Unemployment Benefit Check Stub, Previous Employer Termination Letter or similar document(s).

Your previously covered adult (e.g., spouse) or dependents may also qualify. Please call 866-706-2400 for instructions.

If accepted, your medicines will ship in 90-day supplies directly to your home address for up to one year or until you become insured, whichever occurs first. Please allow 2-3 weeks for processing. Please call 866-706-2400 if you have any questions.

STEP 1 Fill in all shaded areas of this application form.

STEP 2 Place the completed and signed application and copy of your proof of unemployment in a stamped envelope. Also include an original prescription if medicine is a controlled substance, or if you have less than 3 refills remaining on your current prescription.

STEP 3 Mail to:
Pfizer MAINTAIN
PO BOX 66549
St. Louis, MO 63166-6549

Patient Name:		Date of Job Loss: ____/____/____	
Patient Street Address (No PO Box):			
1	City:	State:	Zip Code:
	Telephone: (____) ____-____	Date of Birth: (MM/DD/YY): ____/____/____	
	E-Mail:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

PRESCRIPTION TRANSFER INFORMATION

Please attach original prescriptions for controlled substances and include a copy of your identification (e.g. driver's license). For all other medicines, please fill out the prescription transfer information below.

Pharmacy Name:		Pharmacy Telephone: (____) ____-____	
Doctor Name:		Doctor Telephone: (____) ____-____	
2	Drug Name:	Strength:	Prescription #:
			# of Refills Remaining:
	Drug Name:	Strength:	Prescription #:
			# of Refills Remaining:
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 _____			
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 _____			
List other prescription and over-the-counter medications:			

Patient Declaration – By signing below, I affirm that my answers are complete, true and accurate to the best of my knowledge.

I understand that:

- Pfizer MAINTAIN is a temporary program and enrollment will be accepted until December 31, 2009.
- Completing this application form does not ensure that I qualify for Pfizer MAINTAIN
- Pfizer may verify the accuracy of the information I have provided and may ask for more information.
- Any medications supplied as part of the Pfizer MAINTAIN program shall not be sold, traded, bartered or transferred.
- Pfizer reserves the right to change or cancel the Pfizer MAINTAIN 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 the Pfizer MAINTAIN program:

- I currently do not have any prescription drug coverage and would have not been able to pay for my medicines and continue my therapy, due to my unemployment and uninsured status, without this program.
- I have had a valid prescription for a Pfizer medicine for at least 3 months prior to my unemployment and program enrollment.
- I will promptly contact the Pfizer MAINTAIN program if my unemployment status or insurance coverage changes.

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 Pfizer MAINTAIN 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 Pfizer MAINTAIN program or other health-related topics.

Original Patient's Signature	X	Date:
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