

Thank you for downloading this patient assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

PLEASE REMEMBER: Send your completed application to the address on the form, **NOT** NeedyMeds.

Other cost saving information found on NeedyMeds.org

Copays, Coupons, Rebates & More:

- Discounted over-the-counter drugs, prescription medicines, and medical supplies.

Free, Low-Cost, and Sliding Scale Clinics:

- Includes medical, dental, mental health and substance abuse clinics across the U.S.

Diagnosis-Based Assistance Programs:

- Database for help affording expenses related to a specific healthcare condition.

\$4 Generic Discount Drug Program:

- A great resource for finding generic medications at a discounted price.

Retreats, Camps, Recreational Programs and Scholarships:

- For people of all ages living with a specific diagnosis.

Government Programs:

- Government funded healthcare programs, and other helpful resources, per state.

Medical Transportation:

- Programs that can provide medically related transportation or travel expenses.

Thank you for using NeedyMeds. Please call our toll-free helpline 1-800-503-6897 9am-5pm ET Monday-Friday with any questions.

Sincerely,



Ruth Rowe
President, NeedyMeds

NeedyMeds Drug Discount Card

Simply bring the Card with your prescription to a participating pharmacy to save on:

- Prescription medications
- Over-the-counter medicines written as a prescription
- Pet prescription medicines purchased at the pharmacy*

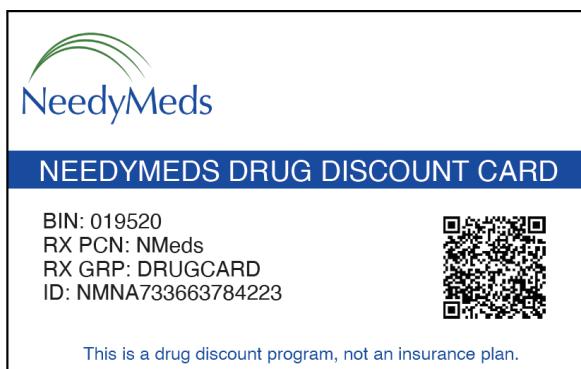
The card can't be combined with insurance or government programs. But if the card provides a better price, it can be used instead of insurance or a government program.

*Not valid at all pharmacies for pet medicines.

A few other points to remember about the NeedyMeds Drug Discount Card:

- It's free, anonymous, and never expires
- It doesn't require activation or registration
- It has no insurance, residency, or income guidelines
- It is accepted at 65,000+ pharmacies nationwide

Visit NeedyMeds.org or call 1-800-503-6879 to learn about additional healthcare savings resources. We're here to help.



How to Apply for Participation in the Nurtec Patient Assistance Program

Physician can initiate a request for patients for participation in the Patient Assistance Program by:



FAX:

Fax a completed and signed Prescription Enrollment Form or prescription along with the required documentation to 866-515-0970



MAIL:

290 West Mount Pleasant Ave
Building 2, 4th Floor, Suite 4210
Livingston, NJ 07039 United States
NPI: 1538590690

Patient Support Enrollment Form for

Patient Eligibility[†] for the Pfizer Patient Assistance Program

In order to be considered for the Pfizer Patient Assistance Program, you must:

- Be uninsured or government insured and unable to afford your co-payment. Government insurance includes, but is not limited to, Medicare, Medicaid, Champus/TRICARE and VA.
 - *Commercially insured (e.g., insurance through your job or through a Federal Employer Plan) patients regardless of insurance coverage are not eligible.*
- For Medicare Part D/Medicare Advantage Patients Only:
 - Enroll in the *Medicare Prescription Payment Plan[‡]* and
 - Confirm that you have not met your annual out-of-pocket costs (and therefore do not yet have a \$0 co-payment for covered medicines)
- Work with your physician's office, pharmacy, and/or insurance company to understand your co-payment and total prescription costs for the year which you are requesting assistance **AFTER:**

[†]Eligibility rules are subject to change at any time.

1. Prior Authorization obtained (if required by your insurer) or have been denied coverage due to drug not on formulary/drug not covered by government insurer; provided that patient/provider has exhausted all appeal options and there is a letter document such AND
2. Enrolling in the *Medicare Prescription Payment Plan* (for Medicare Part D/Medicare Advantage Patients only).
 - Have an inability to afford your prescription costs and attest to this.
 - Have an FDA-approved diagnosis for the Pfizer product(s) prescribed.
 - Meet the income requirements – Your annual household pre-tax income cannot exceed 300% of the Federal Poverty Level, adjusted for household size.
 - Be a resident of the United States (U.S.) or an applicable U.S. territory.
 - Have a valid prescription written by a healthcare provider licensed in the U.S. or an applicable U.S. territory and be treated in the outpatient setting of care.

IMPORTANT NOTE: Commercially insured patients are not eligible to enroll in the Pfizer Patient Assistance Program, even if the medication is not covered by the commercial insurance plan.

Enrollment Checklist for Patients

Patients/caregivers can complete, sign, and submit their portion of the Enrollment form by completing this form using the following instructions. (Pages 2-4 should be completed by the patient or caregiver.) When completing these pages, keep the following points in mind:

- Complete **Section 5** and either attach proof of income or complete **Section 6** to consent to Electronic Income Verification.
- Include copies of the front and back of your medical and pharmacy insurance cards
- Review and provide signatures for **Sections 4, 6 and 7**
- Medicare D patients only - Review and sign **section 3** certification.

Enrollment Checklist for HCP

HCPs can complete and submit Enrollment Forms OR complete this form using the instructions below. (Pages 5 and 6 should be completed by the healthcare provider.) Fill out every section for all patient enrollment requests and:

- Patient information **Section 8**
- Read the attestation and sign the consent statement in **Section 11**
- On-label Certification **Section 11**
- Sign the Certification in **Section 12**
- If the patient is applying for the Pfizer Patient Assistance Program, review the eligibility requirements above and complete the required **Section 13**

[†]The Pfizer Patient Assistance Program requires prior enrollment in the voluntary *Medicare Prescription Payment Plan* for products covered and reimbursed by Medicare Part D/Medicare Advantage Plans. Contact your prescription health insurance plan to learn more.

New

Re-enrollments



Patient Information to Complete

1 Patient Information					*Required fields		
Patient Name (First/MI/Last)*		Patient DOB (mm/dd/yyyy)*			Sex*	Male	Female
Street Address*							
City*				State*		ZIP Code*	
Phone*		H	M	W	Email Address		
Best Time to Contact	Morning	Afternoon	Evening	Preferred Language (if not English)			
Representative (if applicable)							
I permit the Pfizer Patient Assistance Program to speak and write to the following person(s) about this form, and I permit the person(s) to sign any documents related to the program on my behalf:							
First Name:		Last Name:					
Relationship to Patient:		Telephone:					
If signed by patient representative, please indicate below the authority to act on behalf of patient: Court Appointed Guardian Power of Attorney, including authority to make healthcare decisions Other _____							

2 Patient Insurance Information

IMPORTANT NOTE: Commercially Insured Patients are not eligible for the Pfizer Patient Assistance Program[§]

Prescription Insurance

Check Insurance Type*: None (Skip to Section 4)	Medicare	Medicaid	Other
Insurance Name*			
Insurer's Phone*			
RX Policy/Medicare Beneficiary ID #*			
RX Group #*			
RX BIN #*			
RX PCN #*			

Medicare Part D Plan Name (if applicable)

Address		
City	State	ZIP Code

Note: Include copies of the front and back of your medical and pharmacy insurance cards with your enrollment form.

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3 Required Certification for Medicare Part D/Medicare Advantage Patients Only:

***Required fields**

By signing below, I certify that I:

- Have enrolled in the voluntary Medicare Prescription Payment Plan (allows patients to pay their prescription drug costs in capped monthly payments instead of all at once),
- Understand my prescription costs after my healthcare provider has obtained Prior Authorization (if required by my insurer) and that, once I meet my out-of-pocket maximum, I will have to pay \$0 for covered medicines for the remainder of the year,
- Have NOT paid my \$2,000 total (including deductible) prescription costs for the year which I am requesting assistance (my out-of-pocket maximum has not been met),
- And cannot afford my prescription cost for the Pfizer Product(s) prescribed.

<hr/>	<hr/>	<hr/>
Patient Signature* (Patient or patient representative)	Patient representative name (please print)	Date*

If signed by patient representative, please indicate below the authority to act on behalf of patient:

Court Appointed Guardian Power of Attorney, including authority to make healthcare decisions Other _____

4 Patient Consent to Receive Communications  **This is required for all services**

***Required fields**

By signing this form, I agree to receive communications from Pfizer, Nurtec Patient Assistance Program, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer or parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number(s) provided. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Nurtec Patient Assistance Program at 866-473-0088, Monday through Friday, 8:30 am - 8:00 pm ET.

<hr/>	<hr/>	<hr/>
Patient Signature* (Patient or patient representative)	Patient representative name (please print)	Date*

If signed by patient representative, please indicate below the authority to act on behalf of patient:

Court Appointed Guardian Power of Attorney, including authority to make healthcare decisions Other _____

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5 Patient Financial Information		<input checked="" type="checkbox"/> Required if requesting financial assistance services, including but not limited to the Pfizer Patient Assistance Program.[§]	*Required fields	
My provider or pharmacy has reviewed my insurer-required co-payment with me and I certify that I am unable to afford this.				Yes No
Total Number of People Within Household (including applicant)*	Total Annual Household Income* \$			
<p>If you choose not to opt in for Electronic Income Verification in Section 4, you must submit documentation for household to support the financial information you've listed.</p> <p>If patient does not authorize an electronic income verification, one of the following document(s) may be provided:</p> <ul style="list-style-type: none"> a. Most recent federal tax return (form 1040 or 1040EZ) b. Wage and tax statement (W-2 forms) c. Social security, pension, or railroad retirement statements (SSA-1099 or similar) d. Statements of interest, dividends, or other income (1099-INT, 1099, 1099-DIV, or similar forms) e. Last two (2) recent pay stubs 				

6 Patient Privacy and Consent (Read and sign below:)		*Required fields
<p>Patient Authorization for Electronic Income Verification (Optional, but may reduce application review time) I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Report Act authorizing Pfizer Inc. to obtain information from my credit profile or other information from Experian Income View. I authorize Pfizer Inc. to obtain such information solely for the purpose of determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I am entitled to a copy of this authorization upon request. This Authorization shall be valid for one (1) year from the date of the signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to PO Box 8509, Somerville, NJ 08876, but this cancellation will not apply to any information already in use or disclosed through this Authorization. Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements and agree to the outlined terms.</p>		
<hr/> Patient Signature* (Patient or patient representative)	<hr/> Patient representative name (please print)	<hr/> Date*
<p>If signed by patient representative, please indicate below the authority to act on behalf of patient:</p> <p>Court Appointed Guardian Power of Attorney, including authority to make healthcare decisions Other _____</p>		

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7 Pfizer Patient Assistance Program[§] Certification, Attestation, and Privacy Disclosures

*Required fields

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 the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

Patient Declaration: By signing below, I certify that I cannot afford my medication, and 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 enrollment form does not guarantee that I will qualify for the Pfizer Patient Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by the Pfizer Patient Assistance Program shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Pfizer Patient Assistance Program, Pfizer will notify my Part D Plan of my enrollment in the Pfizer Patient Assistance Program. If I am a commercially insured patient, I cannot receive assistance through the Pfizer Patient Assistance Program even if my prescription is not covered by the commercial insurance plan. Any employer funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that I am a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan. I certify and attest that if I receive medicine(s) provided by Pfizer through the Pfizer Patient Assistance Program: I will promptly contact the Pfizer Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D true out-of-pocket costs (TrOOP) for prescription drugs. I will not submit claims, seek reimbursement or credit for 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 medicines through the Pfizer Patient Assistance Program. I have a signed copy of a current and completed Patient Authorization to Share Health Information Form on record with my Prescriber so that my Prescriber may share health information about me with the Pfizer Patient Assistance Program, Pfizer Inc., and the Pfizer Patient Assistance Foundation™ Inc.

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Pfizer Inc., the Pfizer Patient Assistance Foundation, Pfizer affiliates and its vendors (collectively, "Pfizer"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Pfizer so that Pfizer may provide me with various support and information to help me access a Pfizer medicine, which may include the following, depending on my program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
 - Assisting with identification of prior authorization requirements
 - Assisting with identification of requirements of your insurer for appeal of a denied claim
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Sending me a device and starter kit (where appropriate)
- Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities

- Providing me with financial assistance resources and information if I'm eligible
- Providing me with surveys about my experience with the program.

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. I understand that I do not have to sign this form and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, Nurtec Patient Assistance Program may not be able to provide me with assistance. I understand that once my health information is shared, it may no longer be protected by federal privacy law. I consent to Pfizer using my health information for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me. I understand that this form will remain in effect for 4 years from the date of my signature unless state law requires a shorter period or unless I provide written notice that I would like to withdraw my approval to share my health information sooner. I may withdraw my consent at any time. If I would like to withdraw my approval, I may contact my physician or I may contact the Pfizer Patient Assistance Program at 1-866-473-0088, Monday through Friday, 8:30 am - 8:00 pm ET. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

Patient Signature* (Patient or patient representative)

Patient representative name (please print)

Date*

If signed by patient representative, please indicate below the authority to act on behalf of patient:

Court Appointed

Guardian

Power of Attorney, including authority to make healthcare decisions

Other _____

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How to Apply for Participation in the Nurtec Patient Assistance Program

Physician can initiate a request for patients for participation in the Patient Assistance Program by:



FAX:

Fax a completed and signed Prescription Enrollment Form or prescription along with the required documentation to 866-515-0970



MAIL:

290 West Mount Pleasant Ave
Building 2, 4th Floor, Suite 4210
Livingston, NJ 07039 United States
NPI: 1538590690



HCP to Complete

8 Patient Information		*Required fields	
Patient Name (First/MI/Last)*		Patient DOB (mm/dd/yyyy)*	
9 HCP Information			
HCP Name (First/MI/Last)*		Professional Designation	
Practice/Institution Name*		Address*	
City*		State* ZIP Code*	
NPI*	Group Tax ID*		Fax*
Email			
Site of Care Location*: Provider's office Hospital outpatient Hospital inpatient Other N/A			
Contact Name*		Contact Phone*	

10 Prescription Information		
Drug		Date
Quantity	Refills (up to 11)	Directions

11 On-Label Certification	
<p><input checked="" type="checkbox"/> This is required for PAP and, if not signed, the patient is not eligible to be considered for the Pfizer Patient Assistance Program.§</p> <p>I certify that my decision to prescribe a Pfizer product is based solely on my independent clinical judgment, and I have prescribed the product for an FDA-approved indication.</p> <hr/> <p>HCP Signature*</p> <hr/> <p>Date*</p>	

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12 Healthcare Provider Certification

I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I authorize Pfizer, and its affiliates, agents, representatives and service providers to act on my behalf for the purposes of transmitting this prescription (if received) to the appropriate pharmacy.

<hr/>	<hr/>	<hr/>
HCP Signature* (Dispense As Written)	HCP Signature* (Substitution Allowed)	Date*

13 Pfizer Patient Assistance Program[§] Healthcare Provider Consent

Required if requesting assistance through the Pfizer Patient Assistance Program.[§]

The information you provide will be used by Pfizer to improve and tailor our products and services to better serve you. The information will also be used by the Pfizer Patient Assistance Foundation™ Inc. and parties acting on their behalf to administer and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs. By signing below, you, the Prescriber, understand and agree to the following: I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable. Any medications supplied by Pfizer as a result of this enrollment 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, nor will any cost related to it be applied toward the patient's true out-of-pocket costs (TrOOP). I certify that the information provided is current, complete, and accurate to the best of my knowledge. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I understand that commercially insured patients are not eligible for the Pfizer Patient Assistance Program, even if their prescription is not covered by the commercial insurance plan. Any employer funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that the patient is a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan. If the patient has Medicare Part D, Pfizer will notify the Medicare Part D Plan of their participation in the Pfizer Patient Assistance Program. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. Pfizer may contact the patient directly to confirm the receipt of medications. The information provided on this enrollment form is subject to random audits and verification. Pfizer may change or cancel this program at any time; Pfizer also reserves the right to terminate my patient's enrollment at any time. I will notify the Pfizer Patient Assistance Program immediately if the Pfizer product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes. I have a signed copy on file of my patient's current and completed Patient Authorization to Share Information Form so that I may share patient health information with the Pfizer Patient Assistance Program, Pfizer Inc., and the Pfizer Patient Assistance Foundation™.

<hr/>	<hr/>
HCP Signature*	Date*

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