MEDICINE CHANGE REQUEST FORM FOR ENROLLED PATIENTS

Connection To Care®
A Pfizer Helpful Answers Program

FOR PRESCRIBER USE ONLY
Use to add a new medicine, or make a change to an existing medicine, for enrolled *Connection to Care* patients.

PLEASE FILL OUT THE FORM BELOW AND FAX TO 866-470-1748

A PATIENT INFORMATION

Patient Name:

Patient Address:

City: **State:** **Zip Code:**

E-mail:

Telephone: (_____) _____ – _____ **Date of Birth: (MM/DD/YY):** ____ / ____ / ____

B

Please indicate the medicine(s) that you wish to add, or change the dosage for, below. Please complete this section for all products for U.S. residents, except Lyrica® *(pregabalin)*. For Lyrica® or residents of Puerto Rico and U.S. Virgin Islands, please see section C below.

Product Name: **Strength:** **Directions:**
(Check One): ☐ **Add** ☐ **Dosage Change**

Product Name: **Strength:** **Directions:**
(Check One): ☐ **Add** ☐ **Dosage Change**

Product Name: **Strength:** **Directions:**
(Check One): ☐ **Add** ☐ **Dosage Change**

Prescriber Signature:

To place ongoing medicine re-orders, visit our Provider Portal at www.PfizerPAP.com, or call 855-742-7497.
This is only valid for use with the Pfizer Connection to Care patient assistance program.

C PATIENT PHARMACY INFORMATION

For Lyrica® and patients residing in Puerto Rico and U.S. Virgin Islands, complete this section and attach original prescription. Please include a copy of your patient's valid government issued photo ID for <u>new</u> Lyrica® prescriptions.

Is the patient allergic to any medications? ☐ No ☐ Yes If yes, please list all:

List all prescription and over-the-counter medications the patient is currently taking:

D

Prescriber Name:

DEA #: **State License #:**

Ship-to Address (No P.O. Box): **Suite #:**

City: **State:** **Zip Code:**

E-Mail:

Office Telephone: (_____) _____ – _____ **Office Fax:** (_____) _____ – _____

E

By signing below, you, the Prescriber, 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 Prescribers.
- 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.
- I have a signed copy on file of my patient's current and completed HIPAA Authorization Form so that I may share patient health information with the *Connection to Care* program, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc.

Original Signature of Prescriber	**X**	**Date:**

Connection to Care is part of the Pfizer Helpful Answers® family of patient assistance programs – a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation.™