VyndaLink
Connecting Access, Reimbursement, and Education

VyndaLink® Enrollment Form

TELEPHONE: 1-888-222-8475 FAX: 1-888-878-8474 ADDRESS: VyndaLink, PO Box 221296, Charlotte, NC 28222

FOR PATIENTS – Please complete the form where applicable and return via mail or fax. All pages must be returned to VyndaLink.

☐ **Check here if reapplying for the Pfizer Patient Assistance Program.†**

1 PATIENT INFORMATION (*REQUIRED)

First Name* ____________ MI ______ **Last Name*** ____________ **Date of Birth** (mm/dd/yyyy)* ________ **Gender*** ☐ Male ☐ Female ☐ Other

Address* ____________ **City*** ____________ **State*** ______ **ZIP*** ______

Primary Phone* ____________ ☐ H ☐ M ☐ W Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Preferred Language If Not English: ________

Secondary Phone ____________ ☐ H ☐ M ☐ W **Email** ____________

Alternate Contact ____________ Relationship to Patient ____________ Phone ____________

Email ____________

1A REQUIREMENT PRIOR TO REQUESTING ASSISTANCE

Your VYNDAMAX prescription must be sent to the Specialty Pharmacy Provider for a benefits verification/test claim and/or you or your healthcare provider must contact your insurance plan directly to obtain your co-payment amount, your out-of-pocket maximum, and amount met toward your out-of-pocket maximum. If you and your healthcare provider do not know which Specialty Pharmacy is in-network with your insurance plan, check here to ask VyndaLink for help: ☐ I do not know who my in-network Specialty Pharmacy is

2 INSURANCE INFORMATION (*REQUIRED) – ☐ Check here if you are reapplying and your insurance information has not changed ☐ Check here if you have no insurance

NOTE: Patients with commercial insurance are not eligible for the Pfizer Patient Assistance Program, even if the medication is not covered by the commercial insurance plan.

Check all that apply.
I am covered by this insurance plan: ☐ Commercial ☐ Medicare Part A/B only ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid ☐ VA benefits ☐ Other (please specify) ____________ ☐ None

My provider or pharmacy has reviewed my insurer-required product costs with me and I certify that I am unable to afford this.* Yes ☐ No ☐
(If Yes, the five fields below are required and can be completed by either you, your healthcare provider, or both.)

Insurer-Required Co-payment ________ Date ________ Specialty Pharmacy Provider ____________

Out-of-Pocket (OOP) Maximum for Prescriptions ________ Amount Met Toward OOP Max ____________

	Primary Medical (e.g., Medicare A/B)*	Primary Prescription Insurance (e.g., Medicare D)*	Secondary Prescription Insurance
	(*REQUIRED only if front and back copies of insurance card[s] are NOT provided)		
Policyholder Name*			
Insurance Name*			
Insurance Phone*			
Policy ID#*			
Group #*			
BIN #*			
PCN #*			
Medicare Part D Insurance (*REQUIRED for all Medicare Part D patients) – Address	City	State	ZIP

2A CERTIFICATION FOR MEDICARE PART D PATIENTS (*REQUIRED if applying for the Patient Assistance Program)

By signing below, I certify that I:

- Have enrolled in the Medicare Prescription Payment Plan and have included documentation of this enrollment (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, brand medicines for the remainder of the year,
- Have NOT paid my total (including deductible) prescription costs for the year for which I am requesting assistance (my out-of-pocket maximum has not been met),
- Cannot afford my prescription cost for the Pfizer Product(s) prescribed.

SIGN X ____________ ____________ ________

Patient or patient representative signature* (must be 18 years or older)‡ Patient or patient representative name (please print)§ **Date***

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

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

3 PATIENT FINANCIAL INFORMATION

NOTE: We must receive proof of income and/or Authorization for Electronic Income Verification (below) to determine eligibility for assistance. (*REQUIRED)

Total Number of People Within Household (including applicant)* ________ **Total Pre-tax Annual Household Income* $** ________

If you choose not to consent to Electronic Income Verification in Section 4, you must submit income documentation for all contributing household members to support the financial information you've listed. Attached is: ☐ Most recent federal tax return (1040/1040-SR form) – **Required unless tax return is not filed** ☐ W-2 form ☐ Other

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.
‡Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
§NOT required if patient signs.
¶Required if patient representative signs.

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

FOR PATIENTS

4 PATIENT AUTHORIZATION FOR ELECTRONIC INCOME VERIFICATION (Optional, but may reduce application review time)

By signing and dating below, I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Reporting 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 must affirmatively agree to the terms in this notice by signing below in order to proceed in the Pfizer Patient Assistance Program financial screening process. I understand that I am entitled to a copy of this Authorization upon request. This Authorization shall be valid from the date of the signature on this form through the enrollment period (unless a shorter time frame is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to VyndaLink at PO Box 221296, Charlotte, NC 28222, but that this cancellation will not apply to any information already used 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.

SIGN X ______________________ ______________________ ______________

Patient or patient representative signature* (must be 18 years or older)‡ | Patient or patient representative name (please print)§ | **Date***

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

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

5 CONSENT TO COLLECT AND USE PERSONAL DATA (*REQUIRED)

Pfizer Inc. ("Pfizer") collects certain Personal Data (described below) about individuals so that it may provide patient support services to eligible patients through the Pfizer Patient Assistance Program, available through VyndaLink (the "Program"). Pfizer is seeking this consent because it needs to collect and use such data, which is considered sensitive data in some jurisdictions, in connection with operation of the Program.

Personal Data Collected and/or Used. The Personal Data Pfizer and its service providers may collect and use includes names, patient identifier, test results, medical records, healthcare provider information, other data that identifies that you are seeking healthcare services, and data otherwise related to your health condition, diagnosis, and/or treatment (collectively "Personal Data").

Purposes of Collection and Use. Your Personal Data will be used for the following purposes:

Your Personal Data will be used by Pfizer who will provide patient support services to eligible patients including, where applicable, determining eligibility for co-pay support and free drug programs.

Duration. By signing this consent to collect and use, I agree that these entities may use the Personal Data to provide applicable patient support services or as permitted or required by applicable privacy laws. I permit such use for two years after the date I sign the consent, unless and until I revoke (i.e., take back) in writing prior to that time.

Revocation. I may revoke my consent at any time, except to the extent that Pfizer has taken any action in reliance on my consent. I understand that if I revoke my consent, it will not have any effect on any collection, uses, or disclosures of my Personal Data that occurred prior to receiving my revocation. To revoke, I understand that I must notify VyndaLink at PO Box 221296, Charlotte, NC 28222 or call 1-888-222-8475, Monday-Friday, 9 AM-6 PM ET.

I understand that my consent to collect and use my Personal Data is voluntary and may be revoked in writing at any time.

I have read this consent and/or had its contents read to me. I fully understand the terms and conditions described above.

Consent to Collect Personal Data:

By signing and dating below, I consent on my own free will and I agree to the collection and use of my Personal Data as described above. I understand that a signed copy of this consent is available to me upon request.

SIGN X ______________________ ______________________ ______________

Patient or patient representative signature* (must be 18 years or older)† | Patient or patient representative name (please print)‡ | **Date***

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

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

6 CONSENT TO RECEIVE TEXT MESSAGES

By providing your phone number, you consent to receive communications from Pfizer with information regarding the Pfizer Patient Assistance Program, available through VyndaLink. You understand that providing this consent is not required or a condition of purchasing any product or services. Message frequency varies. Message and data rates may apply. Complete terms can be found at rebrand.ly/dxzxpa and Pfizer's privacy policy at pfizer.com/privacy. Text STOP to opt out of text messages.

7 PFIZER PATIENT ASSISTANCE PROGRAM† CERTIFICATION (*REQUIRED)

The information you provide will be used by Pfizer Inc. ("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 applying after January 1, 2024, 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 payer, 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 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, and the Pfizer Patient Assistance Foundation Inc.

SIGN X ______________________ ______________________ ______________

Patient or patient representative signature* (must be 18 years or older)‡ | Patient or patient representative name (please print)§ | **Date***

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

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

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

‡Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.

§NOT required if patient signs.

¶Required if patient representative signs.

8 PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (*REQUIRED)

I authorize (i.e., allow) the use and/or disclosure of my Protected Health Information, described below, which is protected under a federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). In general, Protected Health Information is information, including demographic information, which (1) relates to my past, present, or future physical or mental health or condition, the provision of healthcare to me, or the past, present, or future payment for the provision of healthcare to me, and (2) that identifies me or for which there is a reasonable basis to believe can be used to identify me. I understand that this authorization is voluntary.

1. **Person(s) or Class of Person(s) Authorized to Disclose Protected Health Information:** My healthcare providers, including my treating physicians and medical laboratories, that provide healthcare to me and conduct medical testing.
2. **Person(s) or Class of Person(s) Authorized to Receive Protected Health Information:** Pfizer Inc. ("Pfizer"), Pfizer Patient Assistance Program (the "Program") and other authorized service providers of Pfizer.
3. **Description of Protected Health Information that may be Used and/or Disclosed:** My name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that I am seeking healthcare services, and data otherwise related to my health condition, diagnosis, and/or treatment.
4. **Purpose(s) for the Use and/or Disclosure of Protected Health Information:** To determine whether conditions for eligibility under the Program have been met; and to provide me with various support to help me access a Pfizer medicine, which may include the following:
   - Determining my eligibility for and helping me access co-pay support or free drug programs
   - 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
   - Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services
5. **No Conditioning.** I understand that my treatment, enrollment, eligibility and payment under my health plan are not conditioned upon me signing this form and agreeing to permit the disclosure of my Protected Health Information to Pfizer and its authorized service providers.
6. **Right to Revoke.** I may revoke (i.e., take back) this authorization at any time, except to the extent that my healthcare providers have taken any action in reliance on my authorization. I understand that if I revoke this authorization, it will not have any effect on any uses or disclosures of my Protected Health Information that occurred prior to receiving my revocation. To revoke, I understand that I must notify VyndaLink at PO Box 221296, Charlotte, NC 28222 or call 1-888-222-8475, Monday-Friday, 9 AM-6 PM ET.
7. **Expiration of Authorization.** This authorization will remain in full force and effect for two years from the date of this authorization.
8. **Potential for Re-disclosure.** Persons or entities that receive my Protected Health Information under this authorization may not be required by privacy laws (such as HIPAA) to protect the information and they may share it with others without my permission, if permitted by laws that are applicable to them.
9. **Copy of Authorization.** I understand that I am entitled to receive a signed copy of this authorization. I have read this authorization and/or had its contents read to me. I authorize the use and disclosure of my Protected Health Information as described in 1-9 above.

SIGN X ____

Patient or patient representative signature* (must be 18 years or older)†

____ ______________

Patient or patient representative name (please print)‡ **Date***

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

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

☐ Other ____

†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡NOT required if patient signs.
§Required if patient representative signs.

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VyndaLink® Enrollment Form

TELEPHONE: 1-888-222-8475 FAX: 1-888-878-8474 ADDRESS: VyndaLink, PO Box 221296, Charlotte, NC 28222

FOR HEALTHCARE PROFESSIONALS – Please complete the form where applicable and return via mail or fax. All pages must be returned to VyndaLink.

IMPORTANT NOTE: Commercially insured patients are not eligible for assistance. Patients must have an FDA-approved diagnosis to be considered for the Pfizer Patient Assistance Program.†

Patient Full Name* ______________________ **Patient DOB*** ____________

☐ **Check here if the patient is reapplying for the Pfizer Patient Assistance Program.**

9 PRESCRIBER INFORMATION (*REQUIRED)

First Name* ____________ **Last Name*** ____________

Payer-Specific #* ____________ **NPI #*** ____________ **State License #*** ____________

Practice Name* ____________ **Address*** ____________ **City*** ____________ **State*** ______ **ZIP*** ______

Office Contact Name* ____________ **Office Contact Phone*** ____________ **Office Fax*** ____________

Email ____________ Preferred Communication Method: ☐ Phone ☐ Fax

9A REQUIREMENT BEFORE REQUESTING ASSISTANCE AND REQUEST FOR BENEFITS VERIFICATION (if needed)

The VYNDAMAX prescription must be sent to the Specialty Pharmacy Provider for a benefits verification/test claim and/or you or your patient must contact their insurer directly to obtain the patient's co-payment amount, out-of-pocket maximum, and amount met toward their out-of-pocket maximum. If you or your patient do not know which Specialty Pharmacy is in network or if there is a coverage issue that requires research, VyndaLink can conduct a benefits investigation. Check below if a benefits verification is needed.

☐ **Benefits Investigation – Specialty Pharmacy unknown** ☐ **Benefits Investigation – Payer coverage issue**

10 PRESCRIBER CERTIFICATION (*REQUIRED)

The information you provide will be used by Pfizer Inc. ("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™ 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 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.** 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 Health Information Form so that I may share patient health information with the Pfizer Patient Assistance Program, Pfizer, and the Pfizer Patient Assistance Foundation Inc.

SIGN X ______________________ ____________

Healthcare Provider Signature* **Date***

11 SHIPPING INFORMATION (*REQUIRED)

Ship to* ☐ Patient ☐ Prescriber ☐ Other (please provide shipping address—NO PHARMACIES) ____________

Address* ____________ **City*** ____________ **State*** ______ **ZIP*** ______

12 COVERAGE INFORMATION (*REQUIRED)

The product costs were obtained from the payer/pharmacy and I certify that the patient is unable to afford this.* ☐ Yes ☐ No

Insurer-Required Co-payment* ______ **Date*** ______ **Specialty Pharmacy Provider*** ____________

Out-of-Pocket (OOP) Maximum for Prescriptions* ______ **Amount Met Toward OOP Max*** ______

Does the payer require a Prior Authorization?* ☐ Yes ☐ No **Prior Authorization Number‡*** ______ **Prior Authorization Dates‡*** ______

A copy of the Prior Authorization can be submitted to satisfy this requirement.

13 DIAGNOSIS (*REQUIRED)

Primary ICD-10* ____________ Secondary ICD-10 ____________

14 CLINICAL AND PRESCRIPTION INFORMATION NOTE: Patient must have an on-label diagnosis to be considered for the Pfizer Patient Assistance Program. (*REQUIRED)

Rx* ☐ VYNDAMAX 61 mg: One 61 mg tafamidis capsule orally once daily, Quantity #30 capsules (30 days) ____________ **Refills #*** ______

Drug Allergies: ☐ Yes ☐ No If yes, please list medication(s) and associated reaction(s) ____________

Patient's current medication(s) ____________

SIGN X ______________________ ____________

Prescribing Physician Signature* – NO STAMPS **Date**

Note: If you are a New York prescriber, please attach state prescription form. e-Prescriptions should be sent to AmeriPharm (NPI number - 1073692745; NCPDP number - 4351968), or MedVantx under retail pharmacies (NPI number - 1235371535; NCPDP number - 4354180). If you choose to e-Prescribe directly to AmeriPharm or MedVantx, you are certifying you have received patient consent for AmeriPharm or MedVantx and VyndaLink.

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‡Required if a Prior Authorization is required by the payer.

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