



Phone 1-877-744-5675 or Fax 1-800-708-3430
PO Box 220582 Charlotte, NC 28222-0582

ASSISTANCE FORM

This form can be used to apply for patient assistance, appeals assistance and/or request a benefit verification. Please complete the form where applicable and return via mail or fax.

Please check the requested FirstRESOURCE service and the appropriate Pfizer product:

- Patient Assistance, Appeals Assistance*, Insurance Verification

Table with 2 columns listing various Pfizer products like Aromasin, Emcyt, Camptosar, Idamycin, Ellence, and Zinecard with checkboxes.

(Please see full prescribing information available at www.Pfizer.com)

SECTION ONE: PROVIDER INFORMATION (to be completed by provider)

Physician Name, State License #, DEA #, Tax ID

Practice or Facility Name, NPI #

Address, City, State, Zip Code

Shipping Address (if different than above)

Contact Name, Phone, Fax

Indicate amount of Pfizer product requested for patient assistance or provisional product assistance through appeals assistance.

Treatment Start Date, Expected Treatment Completion Date

Dose, Dosing Regimen, Vial Size/# of Vials

Provider Declaration

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I will notify FirstResource immediately if the Pfizer product is no longer medically necessary for this patient's treatment...

Physician Signature, Date



SECTION TWO: PATIENT INFORMATION (to be completed by patient and/or provider)

Patient Name _____ Patient Phone Number _____

Patient Address _____ City _____ State _____ Zip Code _____

Patient Social Security Number _____ Patient Date of Birth _____

Patient Diagnosis and ICD-9 (Only for appeals assistance program and insurance verifications)

SECTION THREE: INSURANCE INFORMATION (to be completed by patient and/or provider)

Please complete any applicable insurance information below.

| | Medicare | Medicaid | Commercial | Other |
|-------------------------------|----------|----------|------------|-------|
| Insurance Company Name | | | | |
| Policy Number | | | | |
| Group Number | | | | |
| Telephone Number | | | | |
| Policy Holder's Name | | | | |
| Policy Holder's Date of Birth | | | | |

Physician's payer-specific provider ID number, if applicable: _____

Has a claim already been submitted to insurance? Yes No

If yes, has the insurance denied coverage? Yes No

Please state denial reason and date(s) of service: _____

SECTION FOUR: FINANCIAL INFORMATION (patient and/or provider complete if requesting product assistance)

Please list the current annual household income for each item listed below. If you do not receive income for a particular item, enter "0." If you have no income, your physician must provide written attestation on their clinic letterhead that you have no income. Each item must be completed.

Number of household members dependent on income stated below (including applicant): _____

| | | | | | |
|--|----|---------------------------|----|-----------------------|----|
| Current annual Salary | \$ | IRA Distributions | \$ | Alimony/Child Support | \$ |
| Social Security | \$ | Interest/Dividends | \$ | Disability | \$ |
| Other Income – Please Explain | \$ | Unemployment Compensation | \$ | Workers' Compensation | \$ |
| Total Annual Income for Entire Household | | | \$ | | |

We must receive proof of income WITHIN 30 DAYS to determine eligibility for product 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, copy of most recent pay stub.

Patient Declaration

I verify and attest that the information I provided to the FirstResource Program is current, complete, and accurate to the best of my knowledge. I understand that I may be contacted to provide additional information to determine my eligibility for the FirstResource Program and provide services to me. I know that all of the information I provide in applying will be used to decide if I can participate in the FirstResource Program and, if I am enrolled, to provide services to me. I understand that my information will be used solely for verification of my insurance coverage and to determine, if applicable, my eligibility for the patient assistance program and by FirstRESOURCE, Pfizer, and other affiliated companies and contractors to administer the FirstResource Program. If I apply to the FirstResource Program, I understand that the FirstResource Program may request documentation to verify my financial or insurance information. I understand that any assistance provided by the FirstResource Program is temporary and that I may be asked to reapply at designated intervals. I understand that I may be liable for provisional product if insurance payment is not received and/or my provider does not adhere to provisional program guidelines. Additionally, I understand that if claims are paid, I may be responsible for product co-payments. I also agree to inform the program and my physician immediately if my income or insurance status changes. I authorize FirstResource, Pfizer, and their affiliated companies and contractors to obtain health information from my healthcare providers, my physician or insurance company(ies) and other information necessary to complete the application process, to verify the accuracy of any information provided with this application, to administer the program and to, if applicable, refer me to, or to determine my eligibility for, other programs or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my treatment. I understand that FirstResource, Pfizer, and their agents and representatives have the right to revise, change, or terminate this program (and the assistance provided) at any time, without notice. I acknowledge that I am a resident of the United States.

Patient/Guardian Signature _____

Date _____

