



Provider Portal Reference Guide

Visit VyndaLinkPortal.com

See VyndaLink Provider Portal FAQs at the tab below.



Introduction

Signing Up for the Provider Portal

Setting Up Your Office





Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

Contents

Introduction

Who Can Use the Portal	 	 	•	 	•	 •	•	 •	•	 •	•	•	 •	3
Portal Capabilities	 	 		 										3

Signing Up for the Provider Portal

Setting Up Your Office

Enrolling Patients Using the Provider Portal

Enrolling a New Patient
Signing the Enrollment Form via Provider Portal
eSign via Email
Viewing the Status of a Patient Enrollment
Managing Incomplete Enrollments
Enrolling Another Patient









Managing Patient Cases in the Provider Dashboard

Reviewing Cases for Patients
Archiving and Unarchiving Patients
Creating Electronic Prior Authorizations
Understanding Electronic Benefits Verification O
Using Secure Messaging
Navigating the Portal Resources Page

eSignature Registration

User Password Information

Forgot Password? Reset

FAQs and Troubleshooting

VyndaLink Provider Portal FAQs							
Portal Records	 •	•		•	 		
User Profile and Messaging		•			 •	•	
Office Administrator		•			 •	•	•
Inviting Another User	 •	•		•	 	•	•
Contacting Support	 •	•		•	 	•	•
My Cases and My Patients	 •	•		•	 •	•	•
Troubleshooting Tips		•	 •	•	 •	•	•

Managing Patient Cases

eSignature Registration

Dutcomes 28

 	 	. 34	

		•	•	•		•			•			•	•	36
-	•	•		•		•	•		·		•		•	36
•	•	•	•							•				36
	•	•	•	•	•		•	•				•		39
	•	•		•	•	•			•	•			•	39
•		•	•	•		•			•	•	•	•	-	39
		•	•	•		•			•	•			-	40

User Password Information

Introduction

Welcome to the VyndaLink Provider Portal. The Portal functions as a platform where healthcare providers (HCPs) can enroll patients in the VyndaLink Program and manage their patients' information.

VyndaLink helps eligible patients connect to access and affordability support and find educational resources to help support their treatment journey with VYNDAMAX[®] (tafamidis).

The VyndaLink Provider Portal allows access to an interactive dashboard, online patient enrollment, and patient management tools. VyndaLink is available to answer questions and troubleshoot Provider Portal issues. For **specific questions** regarding this portal, call the VyndaLink Provider Portal Hotline at 855-764-7357, Monday-Friday 9ам-5рм ЕТ.

For **VyndaLink questions**, call VyndaLink at 888-222-8475, Monday-Friday, 8ам-8рм.

Should you choose to set up the Provider Portal independently, this **Reference Guide** provides step-by-step instructions. The Pfizer Field Access Specialist can provide portal demonstrations, assist with account setup and answer questions about the Provider Portal. You can contact them directly or through your Pfizer Account Specialist.



Tip: the web browser that works best for this portal is Google Chrome.





Who Can Use the Portal

HCPs and their staff can use this portal after VyndaLink verifies their registration. Use these instructions to assist with navigating the portal once you have been provided access.

Portal Capabilities

In the online portal, HCPs can enroll new patients and re-enroll existing patients. Providers can also check the status of an enrolled patient, upload new documents for the patient, and review enrolled patient cases. This tool provides secure access for patient records pertaining to the VyndaLink Program.

The portal also contains VYNDAMAX Patient Assistance Program (PAP) patient status, ship dates, and tracking numbers.



Enrolling Patients

Managing Patient Cases

eSignature Registration

User Password

Information



Signing Up for the Provider Portal



Introduction

Signing Up for the Provider Portal

Setting Up Your Office



Enrolling Patients

Managing Patient Cases eSignature Registration User Password Information

Signing Up for the Provider Portal

Sign Up lease enter your email and password. If you don't have a loak elick Sign Up.

Controllaria Rainbursettient, and Educe	k 🜮								LOg IN H	ere
								User Email		
						(c)		Password		
		2	Create your	account			<u>م</u> آ			Forget your
		s	select your role to co	ntinue	1	r		Remember	Me	
			Ô	U,					Log In	
		X.								
			Provider i	Nurse	0	Other	0			
		_				Continu	e			
	Terms of Use Pr	rivacy Policy								
				MacE	Book Air					
				÷_2_=`*	= ² =	e je je				
//////////////////////////////////////	an 1 - and a second the second			-						-
		/								
Enter Account Please fill out all the inform Title *Last Name Time Zone Eastern Time *Phone Number	Details nation below to continue *First Name									
Enter Account Please fill out all the inform Title *Last Name Time Zone Eastern Time *Phone Number	Details nation below to continue *First Name									
Enter Account I lease fill out all the inform Title *Last Name Time Zone Eastern Time *Phone Number	Details Pation below to continue *First Name	VyndaLia	4 •							
Enter Account	Details nation below to continue *First Name	Sign up SP We've sent y Can't find the If you still ca	uccessful. Please you an email to padmin e email? Try checking in't login, click here to	verify your em	ail. surcebergen. n email or co	.com with a link to ontact your Progra	activate your ac	count.		



Introduction

Signing Up for the Provider Portal



Go to www.VyndaLinkPortal.com.

Step 1. Click "Sign Up" to create a portal account. Existing users with user names and passwords should click "Log In."

Step 2. Select your role to create an account.



Reminder: When you hover over each role, more information about that role will appear.

Step 3. Complete the "Account Details" screen

- Enter your name, email, phone, etc
- Click the link to read the Terms of Use and Privacy Policy

Step 4. Watch for an email from the VyndaLink Portal to your inbox. The email contains further registration directions. Check your spam folder if not found. Within 24 hours of receiving the email, you must take action and log into the portal with the temporary password contained in the email. This is required to create your user account password.

• Password must contain: 8 or more characters, at least 1 uppercase letter, at least 1 lowercase letter, at least 1 number or special character

Step 5. Log in using your portal account user email and password. Enter your 3 security responses for verifying identity if a password is forgotten. Then click "Continue."

Your next steps include "Setting Up Your Office" by "Completing Your Profile," "Linking Your Office," and "Affiliate Providers to Your Office." These steps are required before being able to use the portal. See next section for directions.

Managing Patient Cases





Introduction

Signing Up for the Provider Portal

Setting Up **Your Office**



Setting Up Your Office

Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

Setting Up Your Office

rollment V 3 Email Notification	My Cases	My Patien	ts Resources	Invite User	
Email Notification	n My Off	ices ESign			
			nature		
			Salutation		First Na
Other			Email myemail.com		1104140
			Phone (555) 555-5555		
			Password *****		
	Other	Other	Other	Other Email myemail.com Phone (555) 555-5555 Password ******	Other Salutation Email myemail.com Phone (555) 555-5555 Password ******



Introduction

Signing Up for the Provider Portal

Setting Up **Your Office**



Complete Your Profile

Navigating the "My Information" Page



After logging in, click "Go to My Profile."

On the "My Information" page, you will see the personal information you provided. You can:

- Edit your profile's phone number
- Change your password
- Change your general communication and document communication preferences

Using the "Email Notification" Page

Click "Email Notifications" to indicate how often you wish to receive 3 emails from the portal.

Managing Patient Cases

eSignature Registration **User Password** Information



Setting Up Your Office (cont'd)

	ation <u>My Offices</u> ESignature			
My Offices	Denied		Request New Office	
Al Offices	3			
		Find Your Office		
	Office Name	Search for an office or create a new one.	0	
	City Q. City	Zip Code		
	Search Results:			
	Site Name	Site Address	A	
	Automation Pfizer Copay Site ESNP	Address1 Address2 FORT MILL, SC 29715	+ Add	
	PFIZER HEALTH CARE HOSPITAL	add1 add1 WASHINGTON, DC 20001	+ Add	
	Pfizer no access site	Pfizer no access site 1 CHARLOTTE, NC 28222	a Remove	
	Automation Pfizer Copey Site GQWH	Address1 Address2 FORT MILL, SC 29715	+ Add	
	Automation Pfizer Copay Site JOLG	Address1 Address2 FORT MILL, SC 29715	+ Add	
	Automation Pfizer Copay Site EKAN	Address1 Address2 FORT MILL, SC 29715	+ Add	
	PFIZER ANIMAL HEALTH CLINIC	601 W CORNHUSKER HWY LINCOLN, NE 68521	+ Add	
	PFIZER, INC	10646 SCIENCE CENTER DR SAN DIEGO, CA 92121	+ Add	
	PFIZER ANIMAL HEALTH	LINCOLN RD WHITE HALL, IL 62092	+ Add	
	First	Prev 1 / 2 Next Last	Veur Celestien	
		Cancel Next	Your Selection:	
			Pfizer no access site	×
			Pfizer no access	



Introduction

Signing Up for the Provider Portal

Setting Up **Your Office**



Complete Your Profile (cont'd)

Linking Your Office to the Portal

Each registered user must have offices (HCP sites) and affiliated providers (HCPs) linked to their profile.



- Click "My Offices" in the navigation tab. The screen will look like this image when there are no pending offices.
- Click "Request New Office" to be directed to the "Find Your Office" page.
- Type the appropriate information into the search boxes. Scroll down and look for the correct office.
 - Add the office you want, then click "Next."



Note: Click "add a new office" if you cannot find your office in the Results section and manually search for the office.

Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

Setting Up Your Office (cont'd)





Introduction

Signing Up for the Provider Portal

Setting Up Your Office



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Complete Your Profile (cont'd)

Assigning an Office Administrator to Your Profile



Each office registered to use the portal must have a designated Office Admin to manage the office's registered portal users.



Click "Add an Admin." Fill out the form with your admin's information. If you are the admin, check the box before filling out the rest of the fields.



Note: If you need help determining who should be your Office Admin, click the "Need Help?" link.

Click "Next." An Office Administration Verification Email will be sent to the Office Admin's email address.

Follow directions on email to verify account.

Understanding Pending, Approved, and Denied Offices



VyndaLink must approve adding offices to your account. Offices show as "Pending" on your "My Offices" page until approved.

Click "All Offices" to view all your offices. Each office's status will 5 be marked.



Note: Only "Approved Offices" can be added to or removed from the portal.

Enrolling Patients

Managing Patient Cases

eSignature Registration

User Password Information

Setting Up Your Office (cont'd)

And ADDRESS OF ADDRES							Messages	
A Patient Inspirment 🤟 My Cases My	Patients Resources Invite User							
My information Email Notification My Off	os ESignature							
	Affiliate Provider(s) to you	r Office(s)	í.					
	Please select all Providers to when	you would like	e to be affiliated to the fo	fouring Office				
Rucky Mauet Orthogoardics and Sports 220 NASH MEDICAL ARTS MALL	2 Rocky Mount Ort 229 NASH MEDICAL A Drevider Name	hopaedics RTS MALLA	and Sports Medic	ine Center				
	Q, Name							
	Selected Providers							
	First Name	v	Las/ Name	v	NPI	~		
	Yest		88		6789567628	@ Hore	***	
			If you can't find the	Provider you	ate looking for, add a ne	w provider.		
				Cor	3			

Information Email Noti	fication My Offices ESignature			
Affiliated Provider	Affiliated Provider Site	eSignature Status	Delegated Status	Action
Luke Skywalker	Pfizer Test Site1	Registered	Requested	N/A
uke Skywalker	Pfizer Site1 TD2	Registered	Not Requested	Request Delegate 🔁
oridgepp user	Bridge Hospital	Not Registered	Not Requested	Request Provider to Register
nurse test	Nurse	Pfizer Test Site1	Requested	Approve Deny





Introduction

Signing Up for the Provider Portal



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Affiliate Providers to Your Office

Click the "My Offices" tab. For affiliate providers, type in the provider's NPI or name in the search box. NPI is the surest way to locate the provider.



2

Note: Any providers already affiliated with your office, including your practice, will appear on this page.

Results will appear under the search box, including the provider's name and NPI number. Click "Add," then press "Continue."

If you cannot find the provider you are looking for, click "add a new 3 provider" to manually add that provider.



Reminder: Offices and Providers will remain in a Pending status until VyndaLink is able to contact the office and speak with the Office Provider Portal Administrator to verify these selections.

The Office Administrator should allow 2 business days for VyndaLink to call them to complete the setup and take the status from "pending" to "active." The patient data will not display for that user unless their account is active.

- If the affiliate provider wants to register for eSignature, click "Request" Provider to Register" to send the Provider eSignature link
- If the affiliate provider wants you to be a delegate, click "Request Delegate" to send the provider this email

After VyndaLink approves the Office Administrator, their office and affiliated providers, the Office Administrator is responsible for approving or denying new users and their offices/affiliated providers.

Setting Up **Your Office**

Enrolling Patients

5

Managing Patient Cases





Introduction

Signing Up for the Provider Portal Setting Up Your Office



Enrolling Patients Using the Provider Portal

Enrolling Patients

Managing Patient Cases

eSignature Registration

User Password Information

Enrolling Patients Using the Provider Portal

		Resources In	vite User
Patie	nt Enrollment	: Patient In	formation
			<u></u> 1
Ilment V My Cases My Patients	Resources Invite User		Messages My T
Patient Enrollment:	Patient Information		
Date of Birth MM/DD/YYYY (If you are using Internet Explorer, please type * Address Line 1 Address Line 2 Zip Code 00000 Home Telephone (000) 000-0000	e the date as MM/DD/YYYY in the field) City	* Sta Cell Phone (000) 000-0000	ite
* Email youraddress@company.com			
	We must validate the patient inform next step. Click " Submit Patien Submit Patien	mation before you can proceed to the ent Info" to validate the patient. ent Information	
Patient Enrollment: S	Select Office and Provider		



Signing Up for the Provider Portal



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)



Note: Fields highlighted in red throughout the form signal required information. The form will not send until all fields highlighted in red are completed with accurate information.

Enrolling a New Patient



Navigate to the "Patient Enrollment" tab and go to "Add a New Patient."

- 2 Fill out the fields with the patient's information, then click "Submit Patient Information." You will be notified if the patient is already in the VyndaLink CRM. If the patient is already enrolled in VyndaLink and you are requesting new support for this patient, select the patient from the provider's patient list that displays.
- Select the patient's office and provider on the "Patient Enrollment: 3 Select Office and Provider" page. Press "Continue."

Enrolling Patients

Managing Patient Cases

		Messages My Team My Approver
ne Patient Enro	ollment V My Cases My Patients Resources Invite User	
	Patient Enrollment: Select Brand(s)	
	Please select one or more brands being prescribed to this patient.	
		VYNDAMAX®
	Back	Continue
	Patient Enrollment: Select Service(s)	
	Please select all services for which you would like to enroll this pati	ient. 5
	VYNDAMAX®	PAP
		Reimbursement Support
	Note: Only a combination	
	separately.	n of services are available in single form. If some services are disabled, you would need to submit the enrollment
	separately. Back	Continue
	Back Patient Enrollment: Co	omplete Form
Selected Brands	Back Patient Enrollment: Co	n of services are available in single form. It some services are disabled, you would need to submit the enrollment Continue
Selected Brands	Back Patient Enrollment: Co YNDAMAX* (tafamidis) Patient Information	n of services are available in single form. If some services are disabled, you would need to submit the enroliment Continue
Selected Brands	separately. Back Patient Enrollment: Constrained by the separately of the separatel	omplete Form
Selected Brands V Selected Services Re	separately. Back Patient Enrollment: Co NDAMAX* (tafamidis) Patient Information eimbursement Support Patient Details Gender Female	omplete Form
Selected Brands V Selected Services Re	separately. Back Patient Enrollment: Co YNDAMAX* (tafamidis) Patient Information Patient Details Gender Female First Name Tist Name	omplete Form
Selected Brands Selected Services Re	separately. Back Patient Enrollment: Co NDAMAX* (tafamidis) Patient Information Patient Details Gender Female First Name Test Middle Name	omplete Form
Selected Brands	INDAMAX* (tafamidis) Imbursement Support Patient Information Patient Details Gender Female First Name Test Middle Name	omplete Form
Selected Brands	separately. Back Patient Enrollment: Co Internation Patient Information Patient Details Gender Female First Name Test Middle Name Last Name Test	omplete Form
Selected Brands V Selected Services R	INDAMAX* (tafamidis) Patient Enrollment: Co Impursement Support Patient Information Patient Details Gender Female First Name Test Middle Name Last Name Test Date of Birth 5/10/2023	n or services are available in single rorm. If some services are disabled, you would need to submit the enrollment Continue — — — — — — — — — — — — — — — — — — —
Selected Brands Selected Services Re	INDAMAX* (tafamidis) Back Patient Enrollment: Co Impursement Support Patient Information Patient Details Gender Female First Name Test Middle Name Last Name Test Date of Birth S/10/2023 Patient Address	n or services are available in single form. It some services are disabled, you would need to submit the enrollinent Continue



Introduction

Signing Up for the Provider Portal

Setting Up Your Office



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Enrolling a New Patient (cont'd)

- Click the brand of the medication being prescribed on the "Patient" 4 Enrollment: Select Brand(s)" page. You may only select one brand. Press "Continue."
- Select PAP or Reimbursement Support, or both on the "Patient" 5 Enrollment: Select Service(s)" form. Press "Continue."



Note: Only a combination of services are available in single form. If some services are disabled, you would need to submit the enrollment separately.

Scroll down to the Patient Information section on the "Patient Enrollment: 6 Complete Form" page to continue completing the form.



Reminder: The gray areas on the Patient Information form are prepopulated with the information you provided earlier and cannot be altered. Fields in white can be completed.

Enrolling Patients

Managing Patient Cases

eSignature Registration **User Password** Information

nsurance Information						
Please enter the medical and/or ph	armacy insurance information.					
Does the patient have medica	l insurance?					
No						
Does the patient have pharma	cy insurance?					
No						
	Insurance Information					
	Insurance Information		anco information			
	Please enter the medical and/or pha	innacy insure	ance mormation.			
	Does the patient have medical insur	ance?				
	1964					
8	Primary Medical Insurance					
	* Payer/Insurance Name				* Policy Holder	
	Search Accounts		(۹		
	* Payer/Insurance Phone				Policy Holder Date of Birth	
	Policy Number				Policy Holder Relationship	
					None	
		1				
	Add Medical Insurance 🕀	J				R
Does the patient have pharm	acy insurance?					
\checkmark						
Yes						
Primary Pharmacy Insurance						
* Paver/Insurance Name			* Plan Name			
Search Accounts		0				
Search Accounts						
Policy Number			* Rin #			
• Group Number]	Is Medication Covere	ed?		
			None		•	
Plan Address			Copay Amount			
					,	
Add Pharmacy Insurance	;е 🔂				Remove 💼	



Introduction

Signing Up for the Provider Portal

Setting Up Your Office



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Enrolling a New Patient (cont'd)





Reminder: Make sure to enter the patient's current medical and pharmacy insurances.

Fill out the patient's primary, secondary, and/or tertiary medical 8 insurance information.

Fill out the primary, secondary, and/or tertiary pharmacy 9 insurance information.

Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

Provider Info	
Provider	Prescriber NPI
GOLDEN_PROVIDER_11 GOLDEN	1234568800
Office Information	
Office Information	E-to-to-
GOLDEN_SITE_3	State
Address Line 1 123 This Way Street	Zip Code
Address Line 2	Phone
City	Fax
Contact Email Address	Office Contact Name
Search Accounts	Office Contact Phone
Medical Information Allergies Please add allergies if applicable. You can add information for any allergy tha Add Allergy	at isn't listed below.
Medical Information Alergies Please add allergies if applicable. You can add information for any allergy tha Add Allergy Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis)	at isn't listed below.
Allergies Please add allergies if applicable. You can add information for any allergy that Add Allergy Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis) Add Treatment & Prescription	at isn't listed below.
Allergies Please add allergies if applicable. You can add information for any allergy the Add Allergy ● Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis) Add Treatment & Prescription Diagnosis	at isn't listed below.
Medical Information Alergies Please add allergies if applicable. You can add information for any allergy the Add Allergy Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis) Add Treatment & Prescription Diagnosis Add Diagnosis	at isn't listed below.
Medical Information Allergies Please add allergies if applicable. You can add information for any allergy the Add Allergy Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis) Add Treatment & Prescription Diagnosis Add Diagnosis Diagnostic Test Name	at isn't listed below.
Medical Information Allergies Please add allergies if applicable. You can add information for any allergy the Add Allergy Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis) Add Treatment & Prescription Diagnosis Diagnosis Diagnostic Test Name Add Diagnostic Test Name	at isn't listed below.
Medical Information Allergies Please add allergies if applicable. You can add information for any allergy the Add Allergy Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis) Add Treatment & Prescription Diagnosis Add Diagnosis Diagnostic Test Name Add Diagnostic Test Name File Attachments	at isn't listed below.
Allergies Please add allergies if applicable. You can add information for any allergy the Add Allergy ● Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis) Add Treatment & Prescription ● Diagnosis Add Diagnosis ● File Attachments File Attachments Upload Files Attach supporting documents (e.g. Insurance Card) * Allowed file types: docx, doc, pdf, bmp, xlsx, xls, txt, jpg, tiff, tif, gif, png * Maximum file size: 4.5 MB * Maximum number of files: 5	t isn't listed below.
Allergies Please add allergies if applicable. You can add information for any allergy the Add Allergy ● Treatment & Prescription Please add relevant treatment and prescription information. VYNDAMAX* (tafamidis) Add Treatment & Prescription ● Diagnosis Add Diagnosis ● Diagnostic Test Name Add Diagnostic Test Name File Attachments Upload Files Attach supporting documents (e.g. Insurance Card) * Allowed file stypes: docv, doc, pdf, bmp, xlsx, xls, txt, jpg, tiff, tif, gif, png * Maximum file size: 4.5 MB * Maximum number of files: 5 Image: Upload Files Yupload Files	at isn't listed below.



Introduction

Signing Up for the Provider Portal



Enrolling a New Patient (cont'd)

- Scroll down to the Office Information section of the form. Enter any 10 missing information.
- Scroll down to the Medical Information section and click "Add Treatment & Prescription."
 - Fill out the fields with the patient's treatment information in the Medication section(s)



(12)

Note: Remember to enter all fields about the VYNDAMAX prescription.

Click the "Add Diagnosis" box. Type the primary diagnosis code in the search box and select the correct code.



Note: You can add up to 3 diagnosis codes.

Scroll down to the File Attachments section and attach supporting 13 documents. Press "Done" after uploading the selected files.

Setting Up Your Office

Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

Patient Signature	
Please obtain the patient signature to continue with the enrollment form	
-Signature Options	
None •	
Provider Signature	
Please obtain the provider signature to complete the enrollment	
*Signature Options	
None •	
Cancel	Save Draft
Signature	
eSign Options	
If using 'eSign now', only one signature can be captured. If the other party also intends to use	eSign, then they will need to use the 'email to eSign' optio
Patient Signature	
Please obtain the patient signature to continue with the enrollment form	
*Signature Options	
Signature options	
Patient will sign the enrollment form via eSign 🔹	
*Select eSign option	
Patient will sign the enrollment form via eSign * Select eSign option Patient will eSign now *	
Patient will sign the enrollment form via eSign Select eSign option Patient will eSign now 	
Patient will sign the enrollment form via eSign * Select eSign option Patient will eSign now Provider Signature	
Patient will sign the enrollment form via eSign * Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment	
Patient will sign the enrollment form via eSign * Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment * Signature Options	
Patient will sign the enrollment form via eSign * Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Descrides will sign the enrollment form via eSign	
Patient will sign the enrollment form via eSign Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment Signature Options Provider will sign the enrollment form via eSign	
Patient will sign the enrollment form via eSign • *Select eSign option • Patient will eSign now • Provider Signature • Please obtain the provider signature to complete the enrollment • *Signature Options • Provider will sign the enrollment form via eSign •	
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Patient will eSign now *Orovider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign * Select eSign option Send an email to the provider to eSign	Signature
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option *Provider Email	Signature
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option *Send an email to the provider to eSign *Provider Email Shahan.jamal2@amerisourcebergen.com	Signature
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email *	Signature Patient Signature
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email Cancel	Signature Patient Signature Please obtain the patient signature to continue
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option *Drovider Email to the provider to eSign *Provider Email ① *Shahan.jamal2@amerisourcebergen.com	Signature Patient Signature Please obtain the patient signature to continue
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email *Provider Email Cancel	Signature Patient Signature Please obtain the patient signature to continue *Signature Options Patient will sign the enrollment form via eSign
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now * Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option *Select eSign option *Select eSign option Send an email to the provider to eSign *Provider Email Cancel	Signature Patient Signature Please obtain the patient signature to continue *Signature Options Patient will sign the enrollment form via eSign *Select eSign option
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email Cancel	Signature Patient Signature Please obtain the patient signature to continue "Signature Options Patient will sign the enrollment form via eSign "Select eSign option Patient will eSign now
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email shahan.jamal2@amerisourcebergen.com Cancel	Signature Patient Signature Please obtain the patient signature to continue "Signature Options Patient will sign the enrollment form via eSign "Select eSign option Patient will eSign now
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now. Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email Cancel	Signature Patient Signature Please obtain the patient signature to continue "Signature Options Patient will sign the enrollment form via eSign "Select eSign option Patient will eSign now - None - Patient will eSign now
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email Shahan.jamal2@amerisourcebergen.com Cancel	Signature Patient Signature Please obtain the patient signature to continue *Signature Options Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Patient will eSign now Send an email to the patient to eSign
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email © shahan.jamal2@amerisourcebergen.com Cancel hank you for submitting your enrollment request!	Signature Patient Signature Please obtain the patient signature to continue *Signature Options Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Patient will eSign now Send an email to the patient to eSign *Signature Options
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email Shahan.jamal2@amerisourcebergen.com Cancel hank you for submitting your enrollment request! you would like to view the status of the enrollment.	Signature Patient Signature Please obtain the patient signature to continue *Signature Options Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now - None - Patient will eSign now Send an email to the patient to eSign *Signature Options
Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email Shahan.jamal2@amerisourcebergen.com Cancel hank you for submitting your enrollment request! you would like to view the status of the enrollment, please navigate to the Case List View. Please te that the case(s) you just created may take several minutes to appear on your list.	Signature Patient Signature Please obtain the patient signature to continue *Signature Options Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now - None Patient will eSign now Send an email to the patient to eSign *Signature Options Provider will download, print and sign the enrol
Patient will sign the enrollment form via eSign "select eSign option. Patient will eSign now Provider Signature Please obtain the provider signature to complete the enrollment *Signature Options Provider will sign the enrollment form via eSign *Select eSign option Send an email to the provider to eSign *Provider Email © shahan.jamal2@amerisourcebergen.com Cancel hank you for submitting your enrollment request! you would like to view the status of the enrollment. please navigate to the Case List View. Please ite that the case(s) you just created may take several minutes to appear on your list. you would like to enroll another patient, click here.	Signature Patient Signature Please obtain the patient signature to continue *Signature Options Patient will sign the enrollment form via eSign *Select eSign option Patient will eSign now - None Patient will eSign now Send an email to the patient to eSign *Signature Options Provider will download, print and sign the end



Introduction

Signing Up for the Provider Portal



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Enrolling a New Patient (cont'd)



Identify how the patient and provider will be signing the form. Both signatures are required for patient enrollment.



Note: If the patient is going to eSign the form, an email is sent to the patient with instructions.



Click "Continue" to submit the form.



Note: Any required fields that are incomplete will now display in red.

- You will be directed to the following page stating the results of the 16 enrollment are processing.
- You will be directed to the following page. Click "View and Download **17** Enrollment Form" to download, view and sign the form. Please allow several minutes for the submittal to go through and for the eSign page to open.
- If the provider and patient chose to eSign now, you will be redirected to 18 the following page. Follow the directions on the next page to learn how to eSign the enrollment form.



Setting Up Your Office

Enrolling Patients

Managing Patient Cases

eSignature Registration **User Password** Information

Patient signature	and the second second side of					
Please obtain the patient si *Signature Options	gnature to continue with the er	nrollment form				
None						
None						
comprete this new						
Provider Signature	insture to complete the enco	Imant				
*Signature Options	egnature to complete the ento	and being				
News						
Concelste this field						
Complete this new						
Cancel						Save Draft
N @ Home @ COVID-19 Informatic. 3	COVID-19 Capacity COVID-19 Ra	essurces O Estexty Methemetic gn the enrolement form where	i 🔮 Learn 💦 Pouer2Learn Molcateo.	 O Compliance Education 	C SAP Conduit .	Across Training
A CONTRACTOR OF A CONTRACTOR OFTA CONTRACTOR O		*				
Raminaryst and Mitable	VyndaLink	Adobe Sign				
Dashboard.	Options ~	Adobe Sign	Please sign: [DEMO USE (ONLY) Pfizer Enrollme	nt	Next P
Dashboard Patient Enrollment	Options ~	Adobe Sign	Please sign: [DEMO USE (, which may enclude the totowing, ow faction and neinbactement support, in	ONLY) Pfizer Enrollme ending on the program scalective cluding assistance with identifying	rit y, "petent support activities ") pedent incurer requirements \$	Next P
Dashboard Patient Enrollment My Cases	Options -	Adobe Sign Adobe Sig	Please sign: [DEMO USE (, which may include the totowing, one faction and neinbactement support, in cleim access to co-pay support or free drug	ONLY) Pfizer Enrollme enang on the program (collective cluding assistance with identifying programs	rit 9. "peteet aupport activities () peteet insurer requirements t	Next P
Dashboard Patient Enrollment My Cases	Options ~	* Providing patients with financial assis	Please sign: [DEMO USE (senior may enouse the totowing, dep fostion and neinbacement support, is cleim access to co-gay support or free drug ders about VYNDAMOR, VYNDAGE), e tance resources and information if ele	ONLY) Pfizer Enrollme ending on the program solvective cluding assistance with identifying programs nd packet support activities plan	rit y, "petent support schwises"); perfent incurer requirements t	Next F
Dashboard Patient Enrollment My Cases My Patients Secure Mestasging	Options ~	Adobe Sign and VTNAJHAL." Salanida megumene • Proxiding benefits investigations/vect authorization and appealing a denied • Determining patient wightiby for and • Communicating with heathcare prov • Proxiding patients with financial assis • Proxiding patients with doese mana- jehich may include surveys about pr	Please sign: [DEMO USE (switch may enouge the totowing, dep forfion and neinbursement support, in clean access to co-gay support or the drug dens about VYNDAMOL VYNDAGE), e tence resources and information if elip generat and other educational methols fent experience with Plicer products, o	ONLY) Pfizer Enrolline ending on the program solutione cluding assistance with identifying programs nd patient support activities plate is, as well as information about Pl envices, and programs)	rst y, "penent support activities ") padient insurer requirements t ben's producte, services, and p	Next P or prior
Dashboard Patient Enrollment My Cases My Patients Secure Messaging Resources	Options -	Adobe Sign and VINAPABL® defaultion megamine • Providing barwitts inwelligedons/well sufficientiation and appealing a denied • Determining patient eligibility for and • Communicating with heathcare provi • Providing patients with financial assis • Providing patients with financial assis • Providing patients with doese mana gehich may include surveys about pa	Please sign: [DEMO USE (, which may include the totowing, one faction and neimbaraeneed support, in cleim access to co-pay support or free drug dats about VYNDAMOL VYNDAGE, or tence resources and information if elip gement and other educational metodo tent experience with Plicer products, o	ONLY) Pfizer Enrolline enang on the program somective cluding assistance with identifying programs of packent support activities (bits is, as well as information about Pf envices, and programs)	nt 9. "petient augport activities") petient insurer requirements to ben's products, services, and p	Next P
Dashboard Patient Enrollment My Cases My Patients Secure Messaging Resources	Options -	Adobe Sign and VINAPABL® defamide medumene • Providing baselita investigations/well authorization and appealing a denied • Determinicating with healthcare provi • Providing patients with financial assis • Providing patients with doese mana- johich may include surveys about pe	Please sign: [DEMO USE (Lenion may enouse the totoming, op factors and neinbactement support, in cliefe access to co-gay support or free drug does about VYNDAMOR, VMDAGE, or tence resources and information if ele generat and other educational metalls fort experience with Piper products, o	ONLY) Pfizer Enrolline ending on the program scatterive cluding assistance with identifying programs nd packet support activities gits is, as well as information about Pi envices, and programs)	rit 9. poteet aupport activities 7 perfect insurer requirements t ben's products, services, and p	Next F tr plor regrame
Dashboard Patient Enrollment My Cases My Patients Secure Meanaging Resources Affiliation Management Approver Management	Options -	Adobe Sign and VINAPABL® defamide medamene • Providing benefits investigations/well authorization and appealing a denied • Determinicating patient eligibility for and • Determinicating with healthcare provide • Providing patients with financial assist • Providing patients with doesse mane gehich may include surveys about pe	Please sign: [DEMO USE (centor may enouse the totowing, our faction and neinbactement support, is clein access to co-gay support or the drug ders about VYNDAMO, VYNDAGE, or tence resources and information if eli- generit and other educational materia tent experience with Piper products, or gn Test Docur tercial use	ONLY) Pfizer Enrolline ending on the program solutione clocking assistance with identifying programs nd patient support activities join is, as well as information about Pf envices, and programs)	rit. 9. peteet aupport activities 7. peteet insurer requirements 3 bar's products, services, and p	Next F or prior
Dashboard Patient Enrollment My Cases My Patients Secure Messaging Resources Affiliation Management Approver Management rwite User	Options	Adobe Sign and VINAPABL® defanide medamene • Providing benefits investigations/well authorization and appealing a denied • Determinicating with healthcare provide • Providing patients with financial assist • Providing patients with doesse mana johich may include surveys about pa • Adobbe Si Not for comm or pages 2-4	Please sign: [DEMO USE (centor may enouse the totowing, dep foction and neinbacement support, is clein access to co-gay support or the drug des about VYNDAMO, VYNDAGE, or tence resources and information if elip generit and other educational methols tent experience with Piper products, or tence resources and information tent experience with Piper products, or tence and other educational methols tent experience with Piper products, or tence and other educational methols tent experience with Piper products, or tence and other educational methols tent experience with Piper products, or tence and the educational methols tence and the educational methods tence and tence and tence and tence and tence tence and tence and tence and tence and tence and tence tence and tence and tence and tence and tence and tence and tence tence and tence	ONLY) Pfizer Enrolline erang on the program sometwe ekcing assistance with identifying programs nd patient support activities join is, as well as information about Pf ervices, and programs) Ment Ment	rit. 9. "petent support activities 7. perfect insurer requirements 5 bar's products, services, and p	Next F
Dashboard Patient Enrollment My Cases My Patients Secure Measurging Resources Affiliation Management Approver Massopement Invite User	Options -	Adobe Sign and V1NAPKAL* datased is required Providing based is investigations/well authorization and appealing a denied Determining patient wightily for and Communicating with heathcare provide Providing patients with financial assist Providing patients with financial assis	Please sign: [DEMO USE (senon may encude the totowing, dep faction and membaraement support, in clean access to co-gay support or the drug dens about VYNDAMOU, VMDA(E), or tence resources and information if elip gement and other educational metodo fent experience with Pilcer products, or tence resources and information fert experience with Pilcer products, or tence resources and information fert experience with Pilcer products, or tence resources and information fert experience with Pilcer products, or tence and other educational metodo fert experience with Pilcer products, or tence, complete ell financial chi documentation of your total tences, complete ell financial	ONLY) Pfizer Enrolline ending on the program solutions cluding assistance with identifying programs of patient support activities pitte in, as well as information about Pf envices, and programs)	nt y. "persent support activities" (* perfect incurrer requirements to ben's products, services, and p some management ar sound its, " information, including Directions 19	Next P or plor regrame T
Dashboard Patient Enrollment My Cases My Patients Secure Messaging Resources Affiliation Management Approver Management Invite User	Options -	Adobe Sign and VINAPALS* defauids medumine • Providing baselits investigations/well autorization and appealing a denied • Detamining patient eligibility for and • Communicating with heatthcare provi • Providing patients with financial assis • Providing patients and	Please sign: [DEMO USE (Lenon may mouse the totowing, ore factors and neinbactersent support, in cliefin access to co-gay support of the drug dens about VYNCAMAR, VYNDAGEL, or tence resources and information if ele gement and other educational maturia farit experience with Pilcer products, or generat and other educational maturia farit experience with Pilcer products, or generat and other educational farit experience of poor total is nature, W-2, or other	ONLY) Pfizer Enrolline erang on the program posective clading assistance with identifying programs of potent support activities patient is, as well as information about Pf ervices, and programs)	nt y, "penent augport activities") potient insurer requirements to ben's products, services, and p some management ar assatisk riternation, including Directions 0 potder Phileop and Content in a	Next F regrame T vDesing sector 1
Dashboard Patient Errollment My Cases My Publishs Secure Mesillaging Resources Affiliation Management Approver Management Invite User	Options -	Adobe Sign and VINAPARL® defendent megumene • Providing baselita investigations/well autoritation and appealing a denied • Datamission patient with financial assis • Providing patients with fi	Please sign: [DEMO USE (Lenion may mouse the totoming, orgo factors and neinbactement support, in chim access to co-gay support or free drug dens about VYNCAMOR, VYNDAGEL, or tence resources and information if ele generat and other educational motels fort experience with Picer products, or gen Test Docum encial use server may are source . tence, complete el financial ch documentation of your total te neture, W-2, or other	ONLY) Pfizer Enrolline erang on the program somecove cluding assistance with identifying programs of polient support activities (sta is, as well as information about Pf ervices, and program)	nt. y potent support activities () potent insurer requirements to ther's producte, services, and p Services, and p Services, and p Services, and p Services, and conservices () Services, and conservices () () () () () () () () () ()	Next F tr plor regrame T solosing section 1
Dashboard Patient Erroliment My Cases My Patients Secure Messaging Nescurces Affiliation Management Approver Management	Options **	Adobe Sign and VINAPABL® defauids medumene • Providing baselits investigations/well autorization and appealing a deried • Detaiministing patients with financial assis • Providing patients with financial assis • Providing patients with doese mana- gehich may include surveys about pa- • Providing patients with doese mana- gehich may include surveys about pa- • Compress with doese mana- gehich may include surveys about pa- • Compress with doese mana- gehich may include surveys about pa- • Compress with doese mana- gehich may include surveys about pa- • Compress with doese mana- istored on in section 2 and ath armaal income, such as federal	Please sign: (DEMO USE (centor may enouse the totoming, per factor and neinbacement support, is clein access to co-gay support or free drug ders about VYNEAMOR, VYNEAGE, e tence resources and information if ele generit and other aducational matule fort experience with Piper products, o generit and other aducational matule fort experience with Piper products, o generit and other aducational tences series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series series	ONLY) Pfizer Enrolline erang on the program sometime ekcing assistance with identifying programs of patient support activities. pits is, as well as information about Pf ervices, and program)	nt. portient augport activities 7 perfect insurer requirements 5 ben's peoducte, services, and p serve reserver ar accality. Information, including Directions 9 polder Philosoy and Consent in s 10 polder Philosoy and Consent in s	Next F
Dashboard Patient Enrollment My Cases My Patients Secure Messaging Resources Afdiation Management Approver Management Invite User		Adobe Sign and VINAPABL® defauids mediaments • Providing baselits investigations/well autorization and appealing a denied • Detarministig patient eligibility for and • Detarministig patients with financial assit • Providing patients with financial assit • Providing patients with doesse mans johich may include surveys about pa • Compose were required assist • Detarministic patients with doesse mans johich may include surveys about pa • Compose were required assist • Detarministic patients with doesse mans johich may include surveys about pa • Compose were required assist • Providing patients with doesse mans johich may include surveys about pa • Compose were required assist • Providing patients with doesse mans johich may include surveys about pa • Providing patients with doesse mans johich may include surveys about pa • Compose were required assist • Providing patient with doesse mans • Providing patients with doesse mans • Providing patient with doesse mans • Providing patients with doesse ma	Please sign: (DEMO USE (senior may encude the totowing, dep factors and neinbactement support, is clein access to co-gay support of the drug des about VYNDAMO, VYNDA(E), or tence resources and information if eli- generit and other educational method fort experience with Piper products, or tence access and information for the products, or tence access and information the competition of your total an instant, W-2, or other tence, significature in the docume	ONLY) Pfizer Enrolline erang on the program sometwe decing assistance with identifying programs of patient support activities pite is, as well as information about Pf ervices, and program)	rit. profeet incorer requirements 5 ber's products, services, and p cores examples recer are examined of ormation, including Directions of an Philosy and Constant in a more finance	Next H
Dashboard Patient Enrollment My Cases My Patients Secure Messaging Resources Affiliation Management Approver Management Invite User		Adobe Sign and VINAPABL® defauids megamene • Providing benefits investigations/well autorization and appealing a denied • Determinicating with beatthcare provide • Providing patients with financial assist • Providing patients with doesse mane jokich may include surveys about pro- Providing patients with doesse mane jokich may include surveys about pro- • Providing patients with doesse mane jokich may include surveys about pro- • Compose en request sources m on pages 2-4 • Providing transition in section 2 and ats aroual income, such as federal	Please sign: [DEMO USE (which may encude the holowing, dep factors and neinbactement support, is clein access to co-pay support of the drug des about VYNDAMU, VMDA(E), or tence resources and information if elip generit and other educational methods fort experience with Piper products, or tence all use tences the products of the products, or tences and other educational methods fort experience with Piper products, or tences and other educational methods fort experience with Piper products, or tences and other educational methods fort experience with Piper products, or tences and other educational methods for the products of provided in network way are resourced. The ducation of provided in network way, or other tencies alignature in the docume and the ducational methods and the ducations and the ducation of provided and the ducations and the ducations of provided and the ducations and the ducations of provided and the ducations and the ducation of provided and the ducations and the ducations of provided and the ducations and the ducation of provided and the ducatio	ONLY) Pfizer Enrolline erang on the program sometive cluding assistance with identifying programs of patient support activities pite is, as well as information about Pf ervices, and program)	rit. profesent autoport activities 7: profesent incourser resolutions of p ben'ts products, services, and p control p	Next P

Introduction

Signing Up for the Provider Portal Setting Up Your Office



Signing the Enrollment Form via Provider Portal

Once the enrollment form has been completed in its entirety, the option to eSign the documents will be made available. Select Provider and Patient Signature options.

If present, the patient can electronically sign the enrollment form while at the office by selecting **Patient will eSign now**.

If the patient is not present in the HCP office, you can send a signature request to the patient's personal email. Instructions for eSign via Email are found on the next pages.

- The enrollment form can also be printed and physically signed by the 2 HCP and patient, then faxed to VyndaLink at **1-888-878-8474**.
- Once the signature options are selected, click **Next** to sign the form. 3
 - A PDF of the completed enrollment form will open with a highlighted yellow area for the Adobe Sign.
- Click on each highlighted yellow area to review and electronically sign 5 the form.



Enrolling Patients

Managing Patient Cases

VyndaLink 🧬

👷 🤹 🍰 Play Nurseter 🗸

Thank you for submitting your enrollment request!

If you would like to view the status of the enrolment, please navigate to the Case List View. Please note that the case(s) you just created may take several minutes to appear on your list.

If you would like to enroll another patient, click here.

Adobe-eSign Link





Attestation & Consent

📅 Patient Encolment 🤍 My Cases My Patients Resources Invite User

Optional Attestations:

Please submit documentation to support the financial information you've listed.

- Attached is: Most recent federal tax return
 Attached is: W-2 form
- Attached is: Other
- I attest that my patient's diagnosis was confirmed.

I confirm that my patient is being prescribed VYNDAMAX for the treatment of ATTR-CM.

Please check this box if your patient is currently participating in a tafamidis trial or compassionate use program.

Patient Authorization for Electronic Income Verification (Optional, but may reduce application review time)

Introduction

I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Report Act aut information from my credit profile or other information from Experian Income View. I authorize Pfizer Inc. to obtain such information determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation requested. I understand that I am entitled to a copy of this authorization upon request. This Authorization shall be valid for two (2) ye signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this Authorization at any time by n cancellation to PO Box 220158, Charlotte, NC 28222, but this cancellation will not apply to any information already in use or disclosed Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements, and agree

Required Attestations:

Program.

 \Box

*Patient Consent for Pfizer Patient Assistance Programs (Required if you entered financial information) The information you provide will be used by Pfizer Inc. ("Pfizer"), the Pfizer Patient Assistance Foundation™, and parties acting on the eligibility, to manage and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pf 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-inco true, and accurate to the best of my knowledge. I understand that: Completing this enrollment form does not guarantee that I will qu Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance in 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

Signing Up for

the Provider Portal



Signature

	None	

Provider Signature Please obtain the provider

*Signature Options

-- None --



Signing the Enrollment Fo	
Provider Portal (cont'd)	

6

Click the Type or Draw icon to complete the signature. This example used the Keyboard icon in order to type the name.

7 HCPs and patients must carefully read the Attestation & Consent language and complete the applicable signatures before submitting the form.

gnature to continue with the enrollment form	
signature to complete the enrollment	
•	

Setting Up Your Office

Enrolling Patients

Managing Patient Cases eSignature Registration User Password Information

rm via

	Please sign: Vyn_Pfiz	zerEnrollment Form_Patient.pdf	Next req
		www.Vyn	daLink.com
	VyndaLink 🏈	VyndaLink [®] Enrollment Form: P	atient
	Connecting Access, Reimbursement, and Education	Fields marked with	* are required.
	Complete the required information on pages 2, 3, 4 NC 28222, or submit online to www.VyndaLink.com	l, and 5 and fax to 1-888-878-8474, mail to VyndaLink , PO Box 221296, C I ff applying for the Pfizer Patient Assistance Program, also complete an	Charlotte, d submit
	page 4. If you have questions, please call VyndaLin For Patients	ik at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.	
	1. Patient Information *	*	_
Start	Patient First Name*	Middle Initial Last Name*	_
	Gender [*] Male [*] Female [*] Not Disclosed Date of	f Birth (mm/dd/yyyy)*Email	
	Address Line 1*		
	Address Line 2	*	
	City*	State* ZIP Code*	
	Primary Phone* Alternate	Phone Grant	
	Patient Caregiver Name Careg	iver Phone Caregiver Email Address	
	2. Insurance Information (Please include a copy	of both sides of your insurance and prescription card[s], if you have insurance	e)
Pfizer also may use assurance purpose their operations ar I understand that I and choosing not receive treatment payment from my	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if	or quality brove orove form bility to ders or f I do ders or f I do ders or brove vyndaLink, and/or partie to contact him or her for su that I (and, if applicable, m out of these communication contact him or her for su that I (and, if applicable, m out of these communication contact him or her for su that I (and, if applicable, m out of these communication Mon(Click to change M-8 PM	er permission for Pfizer, es acting on their behal uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET.
Prizer also may use assurance purpose their operations ar I understand that I and choosing not receive treatment payment from my Test Test	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if	or quality and nereby gives his or he brove VyndaLink , and/or partie to contact him or her for su that I (and, if applicable, m out of these communication ders or I do Mone Click to change M-8 PM	er permission for Pfizer, es acting on their behal uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023
Prizer also may use assurance purpose their operations ar I understand that I and choosing not f receive treatment payment from my Test Test Print Name of Patie	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if	or quality and nereby gives his or he brove VyndaLink , and/or partie to contact him or her for su that I (and, if applicable, m out of these communication ders or conta I do Mon Click to change M-8 PM Test Test Signature of Patient*	er permission for Pfizer, es acting on their behal uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date*
Prizer also may use assurance purpose their operations ar I understand that I and choosing not f receive treatment payment from my Test Test Print Name of Patie	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if mt*	or quality and nereby gives his or he brove VyndaLink , and/or partie to contact him or her for su that I (and, if applicable, m out of these communication ders or conta I do Monc Click to change M-8 PM Test Test Signature of Patient*	er permission for Pfizer, es acting on their behal uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date*
Print Name of Care	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt*	or quality and nereby gives his or her for site to contact him or her for site to contact him or her for site to contact him or her for site that I (and, if applicable, mout of these communication out of these communication contact him or her for site that I do form that I (and, if applicable, mout of these communication contact him or her for site that I do items or contact him or her for site that I (and, if applicable, mout of these communication contact him out of these communication contact him on the site to change items or contact him or her for site that I (and, if applicable, mout of these communication contact him out of these communicatity him out of the secontact him out of these communication contact	er permission for Pfizer, es acting on their behal uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to
Prizer also may use assurance purpose their operations ar I understand that I and choosing not f receive treatment payment from my Test Test Print Name of Patie Print Name of Care Representative	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if mt*	or quality and nereby gives his or he orove VyndaLink, and/or partie orm to contact him or her for si orm that I (and, if applicable, m out of these communication out of these communication ders or conta f I do Monc Test Test NHCC Signature of Patient* Signature of Caregiver/Authorized Patient Representative	er permission for Pfizer, es acting on their behal uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient
PTIZET Also may use assurance purpose their operations ar I understand that I and choosing not f receive treatment payment from my Test Test Print Name of Patie Print Name of Care Representative	e my health information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt*	or quality and nereby gives his or herore orove VyndaLink, and/or partie to contact him or her for sut that I (and, if applicable, mout of these communication out of these communication contact him or her for sut of these communication out of these communication contact him on the form. orm bility to out of these communication out of these communication contact him or her for sut of these communication out of these communication contact him on the form. Item Test Test Signature of Patient* Next Signature of Caregiver/Authorized Patient Representative Her section of the Enrollment Form.	er permission for Pfizer, es acting on their behal uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient
PTIZET Also may use assurance purpose their operations ar I understand that I and choosing not f receive treatment payment from my Test Test Print Name of Patie Print Name of Care Representative	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt*	or quality and hereby gives his or hereby give	er permission for Pfizer, es acting on their behal uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient
PTIZET Also may use assurance purpose their operations ar I understand that I and choosing not f receive treatment payment from my Test Test Print Name of Patie Print Name of Care Representative ee next page to continue	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt*	or quality and hereby gives his or he orove VyndaLink, and/or partie orm to contact him or her for si orm that I (and, if applicable, m out of these communication out of these communication ders or conta I do Mon(Click to change M-8 PM Next Test Test Next Signature of Patient* Her section of the Enrollment Form.	er permission for Pfizer, es acting on their behalt uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient
PTIZET AISO MAY USE assurance purpose their operations ar I understand that I and choosing not i receive treatment i payment from my Test Test Print Name of Patie Print Name of Carego Representative ee next page to continue	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt*	And hereby gives his or he VyndaLink, and/or partie to contact him or her for se that I (and, if applicable, m out of these communication contact him or her for se that I (and, if applicable, m out of these communication contact him or her for se that I (and, if applicable, m out of these communication contact him or her for se that I (and, if applicable, m out of these communication contact him or her for se that I (and, if applicable, m out of these communication contact him or her for se that I (and, if applicable, m out of these communication to contact him or her for se that I (and, if applicable, m out of these communication to contact him or her for se that I (and, if applicable, m out of these communication to contact him or her for se that I (and, if applicable, m out of these communication to contact him or her for se that I (and, if applicable, m out of these communication to contact him or her for se that I (and, if applicable, m out of these communication to contact him or her for se that I (and, if applicable, m out of these communication to contact him or her for se Meters (Mere 1000 Click to change Meters section of the Enrollment Form. mer Disclosure and to do business	er permission for Pfizer, es acting on their behali uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient Click to Sign 2
PTIZET Also may use assurance purpose their operations ar I understand that I and choosing not i receive treatment i payment from my Test Test Print Name of Patie Print Name of Carego Representative ee next page to continue By sign electro	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt*	And hereby gives his of hereby gives hereby give	er permission for Pfizer, es acting on their behali uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient Click to Sign 2
PTIZET AISO MAY USE assurance purpose their operations ar I understand that I and choosing not i receive treatment i payment from my Test Test Print Name of Patie Print Name of Carego Representative ee next page to continue By sign electro	e my nealth information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt*	Ar quality and hereby gives his or hereby give	er permission for Pfizer, es acting on their behali uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient Click to Sign
PTIZET AISO MAY USE assurance purpose their operations ar I understand that I and choosing not i receive treatment payment from my Test Test Print Name of Patie Print Name of Carego Representative ee next page to continue By sign electro	e my health information for es and to evaluate and imp nd services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt*	And nereby gives his or here by and hereby gives his or hereby by and hereby gives hereby and hereby gives his or hereby by and hereby gives his or hereby gives hereby by and hereby gives his or hereby gives hereby by and hereby gives hereby and hereby gives hereby and hereby by and hereby gives hereby and hereby gives hereby and h	er permission for Pfizer, es acting on their behalt uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient Click to Sign 2
PTIZET AISO MAY USE assurance purpose their operations ar I understand that I and choosing not i receive treatment i payment from my Test Test Print Name of Patie Print Name of Carego Representative ee next page to continue ee next page to continue By sign electro	e my health information for es and to evaluate and imp od services. I do not have to sign this f to sign will not affect my a from my Healthcare Provid health insurer. However, if nt* fiver/Authorized Patient completing the Healthcare Provid ing, I agree to this agreement, the <u>Consu</u> hically with VyndaLink.	And nereby gives his or her bility to bility to bili	er permission for Pfizer, es acting on their behalt uch purposes. I underst ny him or her) can opt ons at any time by 1-888-222-8475, ET. May 11, 2023 Date* Relationship to Patient Click to Sign 2

yndaLink		C
	3 Vou're all set	
	You finished approving "[DEMO USE ONLY] 52ca3bb1-608a-4451-8772- 57646a095b53.pdF	
	Next, michaelursinij8pflaer.com will sign.	
	We will email the final agreement to all parties. You can also download a copy of what you just approved.	
	Easy to sign. Easy to send.	
	Need your own documents signed? Adobe Sign can help save you time.	

Introduction

Signing Up for

the Provider Portal

 $\langle \widehat{\Box} \rangle$



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

eSign via Email

Patients and providers can sign via Adobe eSign. The eSign via Email option requires initial setup with Adobe Sign. Once it is set up, providers and patients receive emails to complete the signature process.



The email will request a signature. Promptly read and follow the directions in this email. Once the window is open, click the yellow arrow **Start**.

Check the box and agree to the terms of ADOBE eSIGN and then click the 2 blue button **Click to Sign**.

You will see a confirmation screen of your signature. 3

Setting Up Your Office

Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

	Image: Reference in the R	(c)	<form></form>	Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informat Patient First Name* Gender* Male Complete Male Complete the required Male Complete	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier justions, please call VyndaLink at 1-888-222-8475, Monday-F ntion	Commercial use Commercial use Commercial use Commercial use Fiel Commercial use	www.VyndaLink.com Form: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
Abdressention Interview of the decommendation Interview of the decommendation Interview of the decommendation of the decommendatio	Image: Abde Sign Reduction Image: Adde sign Reduction Image: Adde sign Reduction Image: Adde sign Reduction Imade sign Reduction Image: Adde sign Reduc	Abde Sign Ede Ducciment for the formation of the conversion of the formation of the conversion of the formation of the conversion of t	Abde Sign Ede Courseweit voor werken werken in de Verderwerken werken	VynclaLink Connecting Accest, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informat Patient First Name* Gender* Male * Fen * Address Line 1*	Adot Net for VyndaLink d information on pages 2, 3, 4, and 5 and fax to 1-888-878-84 online to www.VyndaLink.com. If applying for the Pfizer Patier pestions, please call VyndaLink at 1-888-222-8475, Monday-F ntion	Esign Test Do commercial use Enrollment Fiel A, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET. st Name*	www.VyndaLink.com orm: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
<form><complex-block><complex-block></complex-block></complex-block></form>	<form><complex-block></complex-block></form>	<complex-block>Image: A state of the state</complex-block>	<complex-block><complex-block><complex-block><complex-block><complex-block><form><form></form></form></complex-block></complex-block></complex-block></complex-block></complex-block>	VynclaLink Connecting Access. Reinbursement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Address Line 1* Address Line 2	Ado to the second	e Sign Test Do commercial use (* Enrollment F 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET.	Document Www.VyndaLink.com Form: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
<form><form></form></form>	<complex-block></complex-block>	<complex-block>Image: A state of the state</complex-block>	<complex-block>Image: A state of the state</complex-block>	VynclaLink Connecting Access, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen * Address Line 1*	tion	Commercial use Comme	Cument Www.VyndaLink.com Orm: Patient Mds marked with * are required. Rox 221296, Charlotte, complete and submit	
Image: contract of the second seco		<complex-block>To To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To</pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></complex-block>	<complex-block>Image: Control of the control of</complex-block>	VynclaLink Connecting Access, Reimbursemmet, and Education Complete the required NC 28222, or submit to page 4. If you have que For Patients 1. Patient Informat Patient First Name* Gender* Male * * Address Line 1* Address Line 2	dinformation on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier restions, please call VyndaLink at 1-888-222-8475, Monday-F	e Sign Test Do commercial use e Enrollment F fiel 4, mail to VyndaLink, PO B t Assistance Program, also d riday, 8 AM-8 PM ET.	Comment Www.VyndaLink.com Corm: Patient Ads marked with * are required. Nox 221296, Charlotte, complete and submit	
To the second	<form></form>	To the second	To the second	VynclaLink Connecting Accest, Reimbursement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	Image: The set of the se	Commercial use Comme	Cument www.VyndaLink.com form: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
Image: a contract of the second se	Image: A construction of the construction o	Image: Section of the section of	<complex-block>To the second secon</complex-block>	VypclaLink Connecting Access Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Address Line 1* Address Line 2	Image: The set of Birth (mm/dd/yyyy)*	Ur bob e Sign Test Do commercial use e Sign Sign Test Do commercial use e Sign Sign Sign Sign Sign Sign Sign Sign	by brown	
Image: contract of the cont	<complex-block> Image: Signed Signe</complex-block>	To the second	To the second	Vypcalink Connecting Accest, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fer Address Line 1*	tion	dr bob e Sign Test Do commercial use & Enrollment Free 4, mail to VyndaLink, PO B t Assistance Program, also d riday, 8 AM-8 PM ET.	by brown	
Image: state of the state	Image: contract of the state	Image: contract of contract	In the second	VynclaLink Connecting Access Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Address Line 1* Address Line 2	dinformation on pages 2, 3, 4, and 5 and fax to 1-888-878-843 ponline to www.VyndaLink.com. If applying for the Pfizer Patier restions, please call VyndaLink at 1-888-222-8475, Monday-F	<i>or bob</i> e Sign Test Do commercial use * (* Enrollment F tAssistance Program, also of tAssistance Program, also of	by brown	
To the provide the second s	The second se	Image: A contract of the co	<complex-block> Image: State Sta</complex-block>	VynclaLink Connecting Accest, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	Image: The set of Birth (mm/dd/yyyy)*	Commercial use Commercial us	Cument Www.VyndaLink.com Orm: Patient Mes marked with * are required. Rox 221296, Charlotte, Complete and submit	
<form>Image: Control of the control of</form>	<form></form>	To the second	Image: State of the state	VynclaLink Connecting Access, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	Image: The second se	e Sign Test Do commercial use e Enrollment F t Assistance Program, also o riday, 8 AM-8 PM ET.	Comment www.VyndaLink.com orm: Patient Hds marked with * are required. Rox 221296, Charlotte, complete and submit	
<form>Image: contract of the second sec</form>	<form></form>	<complex-block>Image: control of the second seco</complex-block>	<complex-block>Image: A second sec</complex-block>	VynclaLink Connecting Access, Reimbursement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	tion	Commercial use Comme	Comment Www.VyndaLink.com Form: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
<form><form></form></form>	<form></form>	<complex-block>To To <pto< p=""> To <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> To <pto< p=""> <pto< p=""> <pto< p=""> <pto< p=""> To <pto< p=""> <pto< p=""></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></pto<></complex-block>	<form></form>	VynclaLink Connecting Access, Reimbursement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Gender* Male * Address Line 1*	tion	Commercial use C Commercial use C C Commercial use C C C C C C C C C C C C C C C C C C C	Comment Www.VyndaLink.com Form: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
<form><form></form></form>	<form></form>	<form></form>	<form></form>	VynclaLink Connecting Accest, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informat Patient First Name* Gender* Male * Address Line 1* Address Line 2	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-843 boline to www.VyndaLink.com. If applying for the Pfizer Patier jestions, please call VyndaLink at 1-888-222-8475, Monday-F ntion	e Sign Test Do commercial use (* Enrollment F 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET.	Comment Www.VyndaLink.com Form: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
<form><form></form></form>	To the second	<form>Image: control of the second seco</form>	<form></form>	VynclaLink Connecting Access, Reimbursement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1* Address Line 2	tion	Commercial use C Commercial use C C Commercial use C C C C C C C C C C C C C C C C C C C	Comment www.VyndaLink.com form: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
<form>Image: A second sec</form>	<form><complex-block></complex-block></form>	<form></form>	Image: contract of the second seco	VynclaLink Connecting Accest, Reimbursement, and Education Complete the required NC 28222, or submit o page 4. If you have qui For Patients 1. Patient Informat Patient First Name* Gender* Male * Address Line 1* Address Line 2	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier justions, please call VyndaLink at 1-888-222-8475, Monday-F ntion	e Sign Test Do commercial use (* Enrollment Free 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET.	ocument www.VyndaLink.com ocm: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
Image: State Stat	Image: A contract of the state of the sta	To be a consistent of the state of	To be added by the second se	VynclaLink Connecting Access, Reimbursement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Address Line 1* Address Line 2	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier juestions, please call VyndaLink at 1-888-222-8475, Monday-F ntion	e Sign Test Do commercial use C Enrollment F iday, 8 AM-8 PM ET. * st Name*	end www.VyndaLink.com form: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
To be a consistent of the state of	The state of the state	To be a second provide the second provide	To be a consistent of the state of	Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-84 online to www.VyndaLink.com. If applying for the Pfizer Patier testions, please call VyndaLink at 1-888-222-8475, Monday-F	e Sign Test Do commercial use e Enrollment F fiel 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET.	ocument www.VyndaLink.com orm: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
Image: A constraint of the state of the s	<form></form>	Image: State Stat	Image: A second sec	Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-84 online to www.VyndaLink.com. If applying for the Pfizer Patier testions, please call VyndaLink at 1-888-222-8475, Monday-F	e Sign Test Do commercial use e Enrollment F (* Enrollment F (* a mail to VyndaLink, PO B t Assistance Program, also d riday, 8 AM-8 PM ET.	OCUMENT WWW.VyndaLink.com OCOM: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
Image: A construction of the second construct	To be a finite of the second	To be added and the second the second and the second and the second and the second and	<form></form>	Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	Adot Adot Not Disclosed Date of Birth (mm/dd/yyyy)*_*	E Sign Test Do commercial use Commercial 	ocument www.VyndaLink.com orm: Patient Mds marked with * are required. Box 221296, Charlotte, complete and submit	
C Abde Sign Ees Document Image	Abobe Sign Each Concent of the conservation	To be concepted as the second	A Control Contrecontec Conten Contrel Contrel Contrel Contrel Contrel Contrel	Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informat Patient First Name* Gender* Male Complete Male Complete the required Male Complete	Addition Addition Addition VyndaLink online to www.VyndaLink.com. If applying for the Pfizer Patier pestions, please call VyndaLink at 1-888-222-8475, Monday-F tion Middle Initial La male * Not Disclosed Date of Birth (mm/dd/yyyy)*	Sign Test Do commercial use Enrollment F t Assistance Program, also o riday, 8 AM-8 PM ET. st Name*	www.VyndaLink.com orm: Patient Ids marked with * are required. Box 221296, Charlotte, complete and submit	
According to the second seco	Abde Segnession and second and the conservation of the conserva	Accessment in the second sec	Image: Separate Document for the separa	VynclaLink Connecting Accest, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informat Patient First Name* Gender* Male * Fen * Address Line 1*	Add the Not Disclosed Date of Birth (mm/dd/yyyy)*	E Sign Test Do commercial use Enrollment Fiel 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET. st Name*	www.VyndaLink.com orm: Patient Mds marked with * are required. Rox 221296, Charlotte, complete and submit	
Image: State Stat	To be and the second of the second the second the second the second of the second the second of the second of the second the se	The second sec	Image: State Sta	Vunceting Access, Connecting Access, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have qui For Patients 1. Patient Informa Patient First Name* Gender**Male * Fen Address Line 1*	WyndaLink d information on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier uestions, please call VyndaLink at 1-888-222-8475, Monday-F stion tion Middle Initial La male * Not Disclosed Date of Birth (mm/dd/yyyy)*	Commercial use C Enrollment F Fiel 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET. * st Name*	www.VyndaLink.com form: Patient Ids marked with * are required. Box 221296, Charlotte, complete and submit	
The formation of the second se	Image: State Sta	If the commendance is the second se	Image: State Sta	Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	Not for VyndaLink on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier uestions, please call VyndaLink at 1-888-222-8475, Monday-F ttion t	Commercial use (* Enrollment F Fiel 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET. st Name*	www.VyndaLink.com orm: Patient Ids marked with * are required. Box 221296, Charlotte, complete and submit	
To be approved by the second	<form> Image: State and State State</form>	<form></form>	<form> Image: Section of the section of</form>	Vyncalink Connecting Access Connecting Access Reinbursamment, and Education Complete the required NC 28222, or submit to page 4. If you have que For Patients 1. Patient Informat Patient First Name* Gender* Male * * Address Line 1* Address Line 2	VyndaLinl dinformation on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier restions, please call VyndaLink at 1-888-222-8475, Monday-F tion tion Middle Initial La male * Not Disclosed Date of Birth (mm/dd/yyyy)*	(* Enrollment F Fiel 4, mail to VyndaLink, PO B t Assistance Program, also c riday, 8 AM-8 PM ET.	www.VyndaLink.com Form: Patient Ads marked with * are required. Box 221296, Charlotte, complete and submit	
The State	Image: State Sta	f 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		VynclaLink Connecting Access, Reimburgement, and Education Complete the required NC 28222, or submit o page 4. If you have qu For Patients 1. Patient Informat Patient First Name* Gender* Male * Fen * Address Line 1*	VyndaLinl d information on pages 2, 3, 4, and 5 and fax to 1-888-878-84: ponline to www.VyndaLink.com. If applying for the Pfizer Patier pestions, please call VyndaLink at 1-888-222-8475, Monday-F htion tion Middle Initial La male * Not Disclosed Date of Birth (mm/dd/yyyy)*	C [®] Enrollment F Fiel 4, mail to VyndaLink , PO B t Assistance Program, also c riday, 8 AM-8 PM ET.	www.VyndaLink.com form: Patient ids marked with * are required. Box 221296, Charlotte, complete and submit	
<page-header></page-header>	<page-header></page-header>	<page-header></page-header>	<page-header></page-header>	Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen	VyndaLink d information on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier uestions, please call VyndaLink at 1-888-222-8475, Monday-F tition tition Middle Initial La male * Not Disclosed Date of Birth (mm/dd/yyyy)*	(* Enrollment F Fiel 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET.	www.VyndaLink.com form: Patient Ids marked with * are required. Box 221296, Charlotte, complete and submit	
		<text><text><text><text><text><text><text></text></text></text></text></text></text></text>		Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informat Patient First Name* Gender* Male Complete Male Complete the required Male Complete	VyndaLink d information on pages 2, 3, 4, and 5 and fax to 1-888-878-84' online to www.VyndaLink.com. If applying for the Pfizer Patier vestions, please call VyndaLink at 1-888-222-8475, Monday-F tion tion time Middle Initial La male * Not Disclosed Date of Birth (mm/dd/yyyy)*	C Enrollment Frier	www.VyndaLink.com form: Patient Ids marked with * are required. Box 221296, Charlotte, complete and submit	
		Image: A series of the ser		Complete the required NC 28222, or submit o page 4. If you have que For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen Address Line 1*	VyndaLink olinformation on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier uestions, please call VyndaLink at 1-888-222-8475, Monday-F tion tion Niddle Initial La male * Not Disclosed Date of Birth (mm/dd/yyyy)*	Enrollment F Fiel A, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET.	form: Patient Ids marked with * are required. Box 221296, Charlotte, complete and submit	
		One of the second sec	for the construction of t	Complete the required NC 28222, or submit o page 4. If you have qu For Patients Datient First Name* Sender* Male Fen Address Line 1*	VyndaLink d information on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier uestions, please call VyndaLink at 1-888-222-8475, Monday-F ntion male * Not Disclosed Date of Birth (mm/dd/yyyy)*. *	Enrollment F Fiel 4, mail to VyndaLink, PO B t Assistance Program, also o riday, 8 AM-8 PM ET.	dorm: Patient dds marked with * are required. Box 221296, Charlotte, complete and submit	
The second sec	The second sec		A Market Mark	Complete the required NC 28222, or submit o page 4. If you have qu For Patients 1. Patient Informal Patient First Name* Gender* Male Fen Xddress Line 1*	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-843 online to www.VyndaLink.com. If applying for the Pfizer Patier restions, please call VyndaLink at 1-888-222-8475, Monday-F ntion Middle Initial Later Middle Initial	Fiel 4, mail to VyndaLink , PO B t Assistance Program, also o riday, 8 AM-8 PM ET.	ids marked with * are required. Box 221296, Charlotte, complete and submit	
Image: control to the control to control to the control to the control to the co	for the term of term	The second seco	Image: Section of the seconometric section of the section of the section of the	Reimbursement, and Education Complete the required page 4. If you have qu For Patients 1. Patient Informal Patient First Name* Gender* Male Fen * Address Line 1*	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-84: online to www.VyndaLink.com. If applying for the Pfizer Patier restions, please call VyndaLink at 1-888-222-8475, Monday-F ntion Middle Initia Late Middle Initia	Fiel 4, mail to VyndaLink , PO B t Assistance Program, also o riday, 8 AM-8 PM ET. st Name*	aus market with * are required. Box 221296, Charlotte, complete and submit	
Image: A decision of the set of the	To be a set of the set o	Image: A grant and provide the set of the set	But the state of the state o	Complete the required NC 28222, or submit o page 4. If you have qu For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen * Address Line 1*	d information on pages 2, 3, 4, and 5 and fax to 1-888-878-84: online to www.VyndaLink.com. If applying for the Pfizer Patier testions, please call VyndaLink at 1-888-222-8475, Monday-F ation Middle Initia La male [*] Not Disclosed Date of Birth (mm/dd/yyyy)*	4, mail to VyndaLink , PO B t Assistance Program, also d riday, 8 AM-8 PM ET. st Name*	Box 221296, Charlotte, complete and submit	
6 view restance purposes and to evaluate and improve friend the state of the st	6 vot solve the set of the se	6 via the second se	Between the structure of the structur	Compresenter required NC 28222, or submit o page 4. If you have qu For Patients 1. Patient Informa Patient First Name* Gender* Male Fen * Address Line 1*	notine to www.VyndaLink.com. If applying for the Pizer Patier testions, please call VyndaLink at 1-888-222-8475, Monday-F ition Middle Initial La male [*] Not Disclosed Date of Birth (mm/dd/yyyy)*	t Assistance Program, also d iday, 8 AM-8 PM ET.	complete and submit	
	6 Image: the problem is the control by the problem is therewere is the problem is therewere is the problem is	6 reference of the second seco	Image: Branch and the state of the stat	page 4. If you have qu For Patients 1. Patient Informa Patient First Name* Gender* Male * Fen * Address Line 1* Address Line 2	uestions, please call VyndaLink at 1-888-222-8475, Monday-F Ition	iday, 8 ам-8 рм ЕТ. st Name*	_	
For Fatients Image: First Bill	For Fatients For Fatients Fatient Fatient <tr< th=""><th>for Patients For Patients Pressions Pressions</th><th>6 Text attem Memory True Market Market for Market Market for Market Text attem Market for Market Text attem</th><th>For Patients 1. Patient Informa Patient First Name* Gender* Male Fen Address Line 1* Address Line 2</th><th>ntion Middle Initial male [*]Not Disclosed Date of Birth (mm/dd/yyyy)*_</th><th>* st Name*</th><th>_</th><th></th></tr<>	for Patients For Patients Pressions	6 Text attem Memory True Market Market for Market Market for Market Text attem	For Patients 1. Patient Informa Patient First Name* Gender* Male Fen Address Line 1* Address Line 2	ntion Middle Initial male [*] Not Disclosed Date of Birth (mm/dd/yyyy)*_	* st Name*	_	
to take the discussion is a state in the discussion of the di	the state for the state is	the state of the state is	terms first terms in the discourse is the set instal is terms in the set in the set instal is terms in the set instal is ter	1. Patient Informa Patient First Name* Gender* Male Fen Address Line 1* Address Line 2	ntion Middle Initial male [*] Not Disclosed Date of Birth (mm/dd/yyyy)*_	st Name*		
For the start start is the s	The state state is the	A the trist to the the distingtion of the d	A the first time is the biblicest base of Bith (modely)yy?	Patient First Name* Gender* Male * Fen	Middle Initia La	* st Name*		
The third have the second and the second an	Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weight first hame* Weig	Prizer also may use my fleat in information for quality assurance purposes and to evaluate and improve the contact him or her parmission for Prizer, float contact him or her parmission for Prizer, float contact him or her for such purposes. Lunderstant that I do not have to sign with not affect my shifts and these commutations and prizers and the valuate and improve the contact him or her for such purposes. Lunderstant that I do not have to sign with not affect my shifts and these commutations and these commutations and these commutations and services. In understant that I do not affect my shifts and these commutations and these commutations and prizers. In understant that I do not affect my shifts and these commutations and these commutations are prizers. In these commutations are prizers and the second my these to sign with not affect my shifts and these commutations are prizers. Signature of Patient* that 1 (and, if applicable, my him or her) can opt any ment from my health insurer. However, if I do these commutations are prizers. These Test Test Test Test Test Signature of Patient* Date* Date* Date* Date Print Name of Patient* Date Signature of Patient* Date Date Patient Date Patient Signature of Caregiver/Authorized Relationship to Patient Representative Date Patient Wight My that al. Signature of Caregiver/Authorized Relationship to Patient Representative Date Patient Representative Date Patient Patient Representative Date Patient Representative Date Patient Patient Representative Date Patient Patient Representative Date Patient Pa	Particle transmit from the list in the first interview of the interview of th	Patient First Name* Gender* Male * Fen	Middle Initial La	st Name*		
Image: transmission of the particular provides your inclusion of the particular provide your inclusion of the particular prov	with the state with the budget were with the modely yyyr with the state with the modely yyyr with the state with the budget were with the modely yyyr with the state w	Image: State is the if the the definition of the defi	Image: the state of the the determinance provides you with the state of the the the determinance provides of the the state of t	Gender* Male Fen	male [*] Not Disclosed Date of Birth (mm/dd/yyyy)*_			
under start Task and blockses Date of them (minddoyyy)* Enall Address Line 1 Address Line 1 Address Line 1 Disc Line 2 Disc Line 2 Address Line 1 Disc Line 2 Disc Line 2 Disc Line 2 Disc Line 2 Prizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. I understand that 1 do not have to sign this form and choosing not to sign will not affect my ability to receive treatment from my health: insurer. However, if 1 do And nereby gives nis or ner permission for Prizer, VyndaLink (and/or parties acting on their behalf to contact him or her for such purposes. I understand that 1 do not have to sign this form and choosing not to sign will not affect my ability to receive treatment from my health: insurer. However, if 1 do And nereby gives nis or ner permission for Prizer, VyndaLink (and/or parties acting on their behalf to contact him or her for such purposes. I understand that 1 do not have to sign this form and choosing not to sign will not affect my ability to racticity VyndaLink (and and the second to the second	understime real backade base disk interviews Enail Address line 1 Address line 1 Address line 1 Image real backade base disk interviews Prizer also may Use my health information for Quality assurance purposes and to evaluate and improve in ad choosing not to sign will not affect my ability to receive treatment from my health insurer. However, if I do and hereby gives his or her permission for Prizer, YyndaLink , and/or parties acting on their behalf has a line of contact him or her for such purposes. Lunderstan that I (and, if applicable, my him or her) can opt and choosing not to sign will not affect my ability to receive treatment from my health insurer. However, if I do and hereby gives his or her permission for Prizer, YyndaLink , and/or parties acting on their behalf has a line of possible to sign will not affect my ability to receive treatment from my health insurer. However, if I do and hereby gives his or her permission for Prizer, YyndaLink , and/or parties acting on their behalf has a line of possible to sign will not affect my ability to receive treatment from my health insurer. However, if I do and hereby gives his or her permission for Prizer, YyndaLink at 1-838-222-8475, Monday-Friday, 8 AM-8 PM ET. Test Test Test Test Signature of Caregiver/Authorized Patient Representative Relationship to Patient Brint Name of Caregiver/Authorized Patient Signature of the Enrollment Form. Relationship to Patient Brigging I ages to this agreement, the Course Discourge and to do business electrowically with VyndaLink Click to Sign	under: Materia: Net localizes Net localicas Net localizes <	under: Main versue Not better in land opyrophysic End Address Life # Address Life # Difference Difference Prizer also may use my health information for quality assurance purposes and to evaluate and improve in operations and services. Ind hereby gives his of her permission for Prizer, yundalink, and/or parties acting on their behalf in their behalf in the 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 contact him or her for such purposes. I understan that I do not have to sign this form and choosing not to sign will not affect my ability to out of these communications at any time by contact him or her? Print Name of Patient* Task Task May 11, 2023 Signature of Patient* Date* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient* Print Name of Caregiver/Authorized Patient Signature of the comment form. Relationship to Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient* Print Name of Caregiver/Authorized Network with Yudakate. Signature of States and to busites Citch to Signate and the to States	Gender* Male Fen	male Not Disclosed Date of Birth (mm/dd/yyyy)*_	*		
Advess like 1* Cry	Attests lite 1 Attests lite 2 image Place Prizer 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 receive treatment from my Health insurer. However, if I do my health insurer. However, if I do if these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image of Caregiver/Authorized Patient Signature of Patient* May 11, 2023 Image of Caregiver/Authorized Patient Signature of Patient* Date* Image of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative Relationship to Patient Representative Image of Laregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative Relationship to Patient Representative Image of Laregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative Relationship to Patient Representative Image of Laregiver/Authorized Patient Signature of the Enrollment Form. Ick to start Image of Laregiver/Authorized Patient Signature of the Enrollment Form. Ick to start	Attest lite 1 Attest lite 2 Image Propert Bill 2 Prizer also may use my health information for quality Attest lite 2 Prizer also may use my health information for quality Attest lite 2 Prizer also may use my health information for quality Attest lite 2 Prizer also may use my health antormation for quality Attest lite 2 Prizer also may use my health antormation for quality Attest lite 2 Prizer also may use my health antormation for quality Attest lite 2 Prizer also may use my health insurer. However, if Id Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Briend 2 Relationship to Patient Briend 2 Relationship to Patient Briend 2 Relationship to Relevencet	Address Line 1* Support Prizer also may use my nealth information for quality assurance purposes and to evaluate and improve their operations and services. Huderstand that 1 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 Healthcare Providers or and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or add choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or add choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or add choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or add choosing not to sign will not affect my ability to receive treatment from my Health nisurer. However, if 1do Test Test Test Test Vindau fridation of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Patient* Relationship to Patient Representative Determine to condinue completing the Healthcare Provider section of the Enrolment Form. Relationship to Patient Representative Relationship to Patient Representative May 11, 2023 Signature of Date and the construct section of the Enrolment Form. Relationship to Patient Representative	Address Line 1*		Email		
Address time	Address Line 2 Sine 2 2P Code City 2 Sine 2 2P Code Primary Home Sign will not affect my ability or contact him or her for such purposes. Lunderstand that I do not have to sign this form or her device treatment from my Healthcare Providers or payment from my health insurer. However, If I do VirdaLink, and/or parties acting on their behalf to contact ing VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Deter Signature of the Enrollment Form. Relationship to Patient Date* Print Name of Caregiver/Authorized Patient Signature of the Enrollment Form. Relationship to Patient Print Quege to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Re	Address of the second secon	Automating of the second se	Address Line 1				
Attract large Prizer also may Use my nealth information for quaits, assurance purposes and to evaluate and improve their operations and services. I understand that I do not have to sign this form a 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 Test Test Test Test Print Name of Patient* Signature of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient* Signature of Caregiver/Authorized Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to e determent from my Healthcare Provider section of the Enrollment Form.	Address Lot 2 Immurp Phone	Attend the formage thread processing on the procession for PHIzer, it is the procession for PHIzer, it is the procession for the procession for philes of the procession for the procession for philes of the procession for the procession for philes of the procession for the philes of the ph	Attere the 2 Cyping 1 Prizer 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 ad choosing not to sign will not affect my ability to receive treatment from my Health insurer. However, if I do Test Test Test Test Print Name of Caregiver/Authorized Patient Signature of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative Relationship to Patient May 11, 2023 Signature of Caregiver/Authorized Patient Representative Relationship to Patient May 11, 2023 Signature of Caregiver/Authorized Patient Representative Relationship to Patient May 11, 2023 Signature of Caregiver/Authorized Patient Representative Relationship to Patient Bet next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient May 11, 2024 Signature of Datestative Relationship to Patient	Address Line 2				
Test	Prizer also may Use my nealth information for quality assurance purposes and to evaluate and improve their operations and services. and nereby gives his or her permission for Prizer, Syndalink, and/or parties acting on their behalf to contact him or her for such purposes. I understand that I do not have to sign this form and choosing not to sign will not affect my ability or receive treatment from my Healthcare Providers or payment from my Healthcare Providers or payment from my Healthcare Provider section of these communications at any time by contacting Tyndalink at 1.888-222-8475, Monday-Friday, 8 Au-8 PM ET. Image: Test Test Test Test Test Test May 11, 2023 Image: Test Test Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized May 11, 2023 Date* Date* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Date* Definition with use the segment. the Consence Disconce and to do busins Click to sgn May 11, 2023 Signature of Caregiver/Authorized Date* Definit Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Date* Definit Name of Caregiver the test section of the Enrollment Form. Date test section of the Enrollment Form. Date test section of the Enrollment Form.	Image: State of the second	Primury Prove Image: State of the second provider section of the Enrollment Form. Primury Prove Image: State of the second provider section of the Enrollment Form. Primury Prove Image: State of the second provider section of the Enrollment Form. Primury Prove Image: State of the second provider section of the Enrollment Form. Primer Hore Primer Hore Primer Hore Image: State of the second provider section of the Enrollment Form. Primer Hore Primer Hore Primer Hore Signature of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Signature of Caregiver/Authorized Primer Hore Primer Hore Patient Primer Hore Primer Hore Patient Primer Hore Primer Hore Patient Primer Hore Patient Signature of Caregiver/Authorized Patient Print Hore Patien the second prim					
Cry brack is and the second se	Cyr Start Zir Code Primery Brown W drives Phone W drives Phone W drives Phone Primery Brown W drives Phone W drives Phone W drives Phone Primery Phone W drives Phone W drives Phone W drives Phone Primery Phone W drives Phone W drives Phone W drives Phone Primery Phone W drives Phone W drives Phone W drives Phone Assurance purposes and to evaluate and improve their operations and services. M drives phone WyndaLink, and/or parties acting on their behalf to contact him or her for such purposes. I understan that (and, if applicable, my him or her) can opt out of these communications at any time by receive treatment from my Health insurer. However, if I do WyndaLink, at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Print Name of Patient* Signature of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Beresentative W gring, Lagee to this agreement, the comment Store Relationship to Patient Relationship to Very gring, Lagee to this agreement, the comment Store Click to Store Kit to Store	Civing Baser Zir Codet Primary Home Market Phone Market Phone Primary Home Primary Home Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Market Phone Test Test Test Test Test Test Market Ph	Cyn	*	*	*		
Primary Plonet W Attendet Plone W Statusse Language Preference Primary Plonet W Attendet Plone W Statusse Language Preference Primary Plonet W Attendet Plone W Statusse Language Preference Primary Plonet W Attendet Plone W Statusse Language Preference Primary Plonet W Attendet Plone W Statusse Language Preference Primary Plonet W Statusse Language Preference Primary Plonet W Statusse Language Preference Primary Plonet W Statusse Attendet Plone W Statusse Language Preference Statusse Primary Plonet W Statusse M Statusse 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 Health Insurer. However, if I do Contacting VyndaLink, at 1-888-222-8475, Nonaday-Friday, 8 AM-8 PM ET. Primt Name of Patient* Date* Date* Date* Print Name of Caregiver/Authorized Patient Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Very guing: Lagree to this agreement, the Comment Plotese and to do banke	Primary Phone Image Number of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Patient Complexity of the Signature of Caregiver/Authorized Patient Relationship to Patient Sig	Primary House H demander House H demander House Prizzer also may use my nealth 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 and hereby gives his of ner permission for Prizer, Yundatink, and/or parties acting on their behalf to contact him or her for such purposes. I understand that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting Vyndalink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative Relationship to Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign Py sgning 1 gree to this agreement, the consume Disclosure and to do busines ectronically with Vyndalink. Click to Sign	Primey House H demande Hendel H demande Hendel Prizer also may use my nealth 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 and hereby gives his or her permission for Phizer, VyndaLink, and/or parties acting on their behalf to contact him or her for such purposes. I understan that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test May 11, 2023 Image: Test Test Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Representative Determine use to this agreement, the consume Disclosure and to do busines Citck ospin My signing. Lagree to this agreement, the consume Disclosure and to do busines Citck ospin	City*	State* Z	P Code*		
Primery more W Attende Proc W Attende Proc Primery More W Attend Proc W Attende Proc	Primery there W Alternate Phone W Alternate Phone With Alternate Phone W Alternate Phone Image Profession Primery there W Alternate Phone W Alternate Phone Primery theore W Alternate Phone W Alternate Phone W Alternate Phone Primery theore Test Test M Alternate Phone W Alternate Phone W Alternate Phone Primery theore Primery theore Signature of Caregiver/Authorized Relationship to Phatient Primery theage to the the ag	Primey Priver W Attribute Priver Language Preference Privery Privery W Attribute Privery Language Preference Privery Privery Privery Privery M Attribute Privery Privery Privery Privery Privery M Attribute Privery Privery Privery Privery M Attribute Privery Privery Privery Privery M Attribute Privery I understand that I do not have to sign will not affect my ability to receive treatment from my Health insurer. However, if I do M and hereby gives nis or ner permission for Priver, VindaLink, and/or parties acting on their behalf to contact him or her for such purposes. I understan that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Representative Be next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign My guiling Lagree to this agreement, the <u>Consume Disclosurg</u> and to do business Click to Sign	Primey Priore W Merinage Providers and the states in t	*	CH CH	OK to Leave		
Prizer also may use my nealth information for quality assurance purposes and to evaluate and improve their operations and services. and nereby gives his of her permission for Prizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant dhat 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 any time of her can opt out of these communications at any time by contact him or her for such purposes. I understant from my health insurer. However, if I do Image: Test Test Test Test Test Test Test Test	Plizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his or her permission for Phizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant that I do not have to sign this form and choosing not to sign will not affect my ability to contact him or her for such purposes. I understant to sign the insurer. However, if I do out of these communications at any time by contacting VyndaLink , at 1-888-222-8475, May 11, 2023 Print Name of Patient* Tast Tast May 11, 2023 Print Name of Caregiver/Authorized Patient Signature of Patient* Date* Relationship to Patient be environed to the second to the sec	Prizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his of her permission for Prizer, MyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant that I do not have to sign this form and choosing not to sign will not affect my ability to contact him or her for such purposes. I understant that I do not have to sign their behalf to contact him or her for such purposes. I understant that I do not have to sign their behalf to contact him or her for such purposes. I understant that I do not may the sign will not affect my ability to contact him or her for such purposes. I understant that I do not may the latthcare Providers or payment from my health insurer. However, if I do out of these communications at any time by contacting VyndaLink , at 1-888-222-8475, May 11, 2023 Image: Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient By going, I agree to this agreement, the Consume Disclosurg and to do business Click to Sign By signing, I agree to this agreement, the Consume Disclosurg and to do business Click to Sign	Prizer also may use my nealth information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his of her permission for Prizer, MyndaLink , and/or parties acting on their behalf to contract him or her for such purposes. Lunderstand 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 and hereby gives his of her permission for Prizer, MyndaLink , and/or parties acting on their behalf to contract him or her for such purposes. Lunderstant that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1.888-222-8475; Monday-Friday, 8 AM-8 PM ET. Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Bet next page to continue completing the Healthcare Provider section of the Enrollment Form. Signature of Laregiver/Authorized Relationship to Patient By signing, Jagree to this agreement, the consume Disclosure and to business electronically with VyndaLink. Signature of business Cick to Sign	Primary Phone*	Alternate Phone	a Message	eference	
Prizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his of her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understand that I do not have to sign this form and choosing not to sign will not affect my ability to contact him or her for such purposes. I understand that I do not have to sign this form and choosing not to sign will not affect my ability to contact him or her for such purposes. I understand that I do not have to sign this form and choosing not to sign will not affect my ability to contact him or her for such purposes. I understand that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Beging Lagree to this agreement, the Corcurne Disclosure and to do business decronically with VyndaLink. Click to Sign	Prizer also may use my nealth information for quality assurance purposes and to evaluate and improve their operations and services. and nereby gives his of her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understand that I do not have to sign him form and choosing not to sign will not affect my ability to receive treatment from my Health care Providers or payment from my health insurer. However, if I do Image: Test Test Test Test Test Test Test Test	Prizer 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 Health care Providers for payment from my health insurer. However, if I do and hereby gives his or her permission for Prizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understan that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient Be next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By spring, I agree to this agreement, the <u>Consumer Discourge</u> and to do business Click to Sign By spring, I agree to this agreement, the <u>Consumer Discourge</u> and to do business Click to Sign	Prizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his or her permission for Prizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant dhat 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 and hereby gives his or her permission for Prizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Ber gesentative Signature of Caregiver/Authorized Relationship to Patient Ber gesentative Signature of caregiver/Authorized Relationship to Patient Ber ges to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, J agree to this agreement, the constance Discloser and to do business electronically with VyndaLink. Click to Sign		M			
Plizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his or her permission for Plizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. 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 and hereby gives his or her permission for Plizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. 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 and hereby gives his or her permission for Plizer, VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test Test Test Test Test	Prizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and nereby gives his of her permission for Prizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant 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 Image: treatment from my health insurer. However, if I do Test Test May 11, 2023 Print Name of Patient* Signature of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Representative Signature of Caregiver/Authorized Relationship to Patient Bignature of Lage to this agreement, the Consume Disclosure and to do business electronically with VyndaLink. Click to Sign	Prizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his of her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant 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 and hereby gives his of her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant the form my health insurer. However, if I do Image: Test Test Test Test Test Test Test Test	Prizer also may use my nealth information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his or her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understant that 1 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 have to sign this form Test Test and hereby gives his or her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understan that 1 do not have to sign this form and choosing not to sign will not affect my ability to receive treatment from my health insurer. However, if I do not have a set any time by contacting YyndaLink at 1-888-222-8475, Monday-Friday, 8 Am-8 PM ET. Image: Test Test Test Test May 11, 2023 Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient* Better the greesentative Signature of Caregiver/Authorized Relationship to Patient Better they age to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign My spling. Legge to this agreement, the Consume Disclosure and to do business electronically with VyndaLink. Click to Sign					
Prizer 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 VyndaLink, and/or parties acting on their behalf to contact him or her for such purposes. 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 health care Providers or payment from my health insurer. However, if I do VindaLink, and/or parties acting on their behalf to contact him or her for such purposes. I understand that I do not have to sign this form and choosing not to sign the authorized payment from my health insurer. However, if I do Image: Test Test Test Test Test Test Test Test	Prizer 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 VyndaLink, and/or parties acting on their behalf to contact him or her for such purposes. I understand that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-838-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test Test Test Test Test	Prizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his of her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. 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 Health care Providers or payment from my health insurer. However, if I do and hereby gives his of her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understand that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink , at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* May 11, 2023 Signature of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Be next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign Click to Sign By signing 1 agree to this agreement, the Consume Disclosure and to do business electronically with VyndaLink. Click to Sign Click to Sign	Prizer also may use my nealth information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his of her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. 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 Health care Providers or payment from my health insurer. However, if I do and hereby gives his of her permission for Prizer, YyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. I understand that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink , at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Test Test Test Test May 11, 2023 Print Name of Patient* Date* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Be next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign Click to Sign					
Prizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services. and hereby gives his or her permission for Prizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. 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 and hereby gives his or her permission for Prizer, VyndaLink , and/or parties acting on their behalf to contact him or her for such purposes. 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 Image: Test Test Test Test Test Test Test Test	Prizer 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 Test Test Test Test Test Test Test Test	Prizer also may use my nealth 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 mane of Patient* I signature of Patient* May 11, 2023 Print Name of Patient* I signature of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient grage to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink.	Prizer also may use my nealth 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 Test Test Test Print Name of Patient* Signature of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient Representative Relationship to Patient Representative Relationship to Patient Portice of the agreement, the Consume Disclosure and to do business decironically with VyndaLink.					
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 Test Test Test Test Test Print Name of Patient* Print Name of Caregiver/Authorized Patient Representative By sgning. I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink.	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 Test Test Test Print Name of Patient* Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient Representative Signature of the Enrollment Form. By signing, Lagree to this agreement, the <u>Consumer Discloure</u> and to do business electronically with VyndaLink.	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 Test Test Test Print Name of Patient* Print Name of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, Lagree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink.	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 Test Test Print Name of Patient* Isignature of Patient Print Name of Caregiver/Authorized Patient Representative Isign the Healthcare Provider section of the Enrollment Form. Isignature of the Enrollment Form. Isignature of the Enrollment Form. Isignature of the Enrollment Form. It is to the section of the Enrollment Form. Isignature of the Enrollment Form. Isignature of the Enrollment Form. Isignature of the Enrollment Form. Isignature of the Enrollment Form.	TP	fizer also may use my health inform	ation for quality	and hereby gives his	or her permission for Pfizer
Building particles 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 Health care Providers or payment from my health insurer. However, if I do Vyrdatility, and/of parties acting on their befalse that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test Test Test Test Test	Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient By signing, Lagee to this agreement, the Consumer Disclosure and to do business Click to Sign	Big drace purposes and to create 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 VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test Test Test Test Test	Building process and by process and by process. Formations and services. I understand that I do not have to sign this form and choosing not to sign will not affect my ability to contact tim or her for such purposes. I understand that I (and, if applicable, my him or her) can opt out of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of these communications at any time by contact time of the second	P	issurance nurnoses and to evaluate	and improve	Vyndal ink and/or	narties acting on their behal
Inter 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 I do contact mim of ner for such purposes. I Understan that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Image: Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Image: Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business click to Sign Click to Sign	Inter operations and services. Inderstand 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 to contact nim or ner for such purposes. I Understand that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test Test Test Test Test	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 Health care Providers or payment from my health insurer. However, if I do Test Test Test Test Test Test Test Test	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 Health care Providers or payment from my health insurer. However, if I do Test Test Test Test Print Name of Patient* Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. My signing, Lagee to this agreement, the Consumer Disclosurg and to do business electronically with VyndaLink.	a	boir operations and convicts	and improve	to contact him on home	for such purposes. Transformer
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 Health care Providers or payment from my health insurer. However, if I do that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Image: Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Image: Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the Censumer Disclosure and to do business electronically with VyndaLink. Click to Sign	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 to these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Test Test Test Test Print Name of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Signature of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign	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 have the second structure of the second structure of the second structure of Patient* that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475; Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	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 that I (and, if applicable, my him or her) can opt out of these communications at any time by contacting VyndaLink at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET. Image: Test Test Test Test May 11, 2023 Image: Print Name of Patient* Signature of Patient* Date* Image: Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Elick to Sign Click to Sign By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign Click to Sign	t	neir operations and services.		to contact him or her	Tor such purposes. I underst
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 Test Test Test Test May 11, 2023 Print Name of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Representative Relationship to Patient Representative Relationship to Patient Bernelling the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosurg and to do business electronically with VyndaLink.	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 Test Test Test Print Name of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	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 Test Test Test Test Print Name of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing Lagree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink.	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 payment from my health insurer. However, if I do <u>Print Name of Patient*</u> <u>Print Name of Patient*</u> <u>Print Name of Caregiver/Authorized Patient</u> <u>Print Name of Caregiver/Authorized Patient</u> <u>Signature of Caregiver/Authori</u>	I	understand that I do not have to sid	n this form	that I (and, if applica	ble, my him or her) can opt
receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do rest Test Test Test Test Test Test Print Name of Patient* Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. Representative Detertorically with VyndaLink. Click to Sign	receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do Test Test Print Name of Patient* May 11, 2023 Print Name of Caregiver/Authorized Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndeLink.	receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do rest Test Test Print Name of Patient* Print Name of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do rest Test Test Print Name of Patient* Print Name of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. Print Jagree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink.	a	and choosing not to sign will not affe	ct my ability to	out of these commu	nications at any time by
Print Name of Patient* May 11, 2023 Print Name of Patient* Signature of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign	payment from my health insurer. However, if I do Wonday-Friday, 8 AM-8 PM ET. May 11, 2023 Print Name of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink.	Payment from my health insurer. However, if I do Wonday-Friday, 8 AM-8 PM ET. Image: Test Test Image: Test Test Print Name of Patient* Signature of Patient* Date* Image: Test Test Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Print Representative Relationship to Patient Signature of Caregiver/Authorized See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, Lagree to this agreement, the Censumer Disclosure and to do business Click to Sign electronically with tyndatink. Test Test Test Test	Payment from my health insurer. However, if I do Wonday-Friday, 8 AM-8 PM ET. Test Test Test Test Print Name of Patient* Signature of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	0	receive treatment from my Healthcar	e Providers or	contacting Vyndal i	nk at 1-888-222-8475
Payment non-ring nearting nearting nearting nearting near in tool Wondady-Friday, S AM-S PM E1. Print Name of Patient* May 11, 2023 Print Name of Patient* Signature of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Representative Signature of Caregiver/Authorized By signing, J agree to this agreement, the Consumer Disclosure and to do business Click to Sign electronically with Vyndatink. Click to Sign	Print Name of Patient* May 11, 2023 Print Name of Patient* Signature of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	payment norming nearting nearting nearting nearting near the near the consumer Disclosure and to do business electronically with VyndaLink. May 11, 2023 May 11, 2023 Date* Print Name of Patient* Signature of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Print Name of Caregiver Authorized Relationship to Print Name of Caregiver Authorized Patient Signature of Caregiver Authorized Print Name of Caregiver Authorized Patient Signature of Caregiver Authorized Print Name of Caregiver Authorized Pati	payment norm my nearting n		avment from my health insurer. He	Never if I do	Monday-Friday 9 Av	LS DM FT
Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	Test Test Test Test May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	Test Test Test Test May 11, 2023 Print Name of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Patient* Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the <u>Consumer Disclosure and to do business electronically with Vyndatlink.</u> Click to Sign	Test Test Test Test May 11, 2023 Print Name of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	p	bayment from my nealth insurer. Ho	wever, IT I do	wonday-Friday, 8 AM	-OPMEL.
Itest rest Test rest May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing. I agree to this agreement, the Consumer Disclosure and to do business Click to Sign By signing. I agree to this agreement, the Consumer Disclosure and to do business Click to Sign	Itest fest Itest fest May 11, 2023 Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient By signing, I agree to this agreement, the <u>Consumer Disclosure and to do business electronically with VyndaLink.</u> Click to Sign	Itest rest May 11, 2023 Print Name of Patient* Signature of Patient* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Print Name of Caregiver/Authorized Print Name of Caregiver/Authorized	TODAT WAT	Toot Toot	GCAL HERE	1 Test	14000
Print Name of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	Print Name of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to See next page to continue completing the Healthcare Provider section of the Enrollment Form. Signature of Caregiver/Authorized and to do business Click to Sign By signing. I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign The Signature of Caregiver/Authorized	Print Name of Patient* Signature of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to See next page to continue completing the Healthcare Provider section of the Enrollment Form. Expresentative Click to Sign By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign Click to Sign	Print Name of Patient* Date* Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	PRINT HERE	lest lest	Southers Te	ist Test	May 11, 2023
Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign	Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Relationship to Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient	Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Representative Relationship to Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	Print Name of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	p	Print Name of Patient*	Signa	ture of Patient*	Date*
Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	Print Name of Caregiver/Authorized Patient Signature of Caregiver/Authorized Patient Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	P	The Name of Fauent	signa	ture of Fatient	Date
Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign Click to Sign	Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Relationship to Patient By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	PRINT HERE		SIGN HERE		
Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign Click to Sign	Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign Click to Sign	Print Name of Caregiver/Authorized Patient Representative Signature of Caregiver/Authorized Patient Representative Relationship to Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign					
Representative Patient Representative Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. See next page to continue completing the Healthcare Provider section of the Enrollment Form. Click to Sign By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	Representative Patient Representative Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	Representative Patient Patient Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. Patient	Representative Patient Representative Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign		Print Name of Caregiver/Authorized P	tient Signa	ture of Caregiver/Autho	rized Relationshin to
Representative Fattern See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	Representative Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	Representative Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink.	Representative Patient See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	P	Penrecentative	Patio	nt Representative	Patient
See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign 7	See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign 7	See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink. Click to Sign	R	Representative	Pauer	in Representative	Fallent
See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign	See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink. Click to Sign			Deside the second se	fab - Franklin	
By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business click to Sign electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	See	e next page to continue completing the Healtho	are Provider section o	of the Enrollment Form.	
By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.					
By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.					
By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.					
By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.					
By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business Click to Sign electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business Click to Sign electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.	By signing, I agree to this agreement, the <u>Consumer Disclosure</u> and to do business electronically with VyndaLink.					
electronically with VyndaLink.	electronically with VyndaLink.	electronically with VyndaLink.	electronically with VyndaLink.		By signing, I agree to this agreemen	the Consumer Disclosur	e and to do business	Click to Sign
		7	7		electronically with VyndaLink.			click to bight
		7	7		Ciecci officary with vyhtachik.			
		7	7					
	7	7	7					
					POINT HERE POINT HERE POINT HERE See	their operations and services. I understand that I do not have to sig and choosing not to sign will not affer receive treatment from my Healthcar payment from my health insurer. How Test Test Print Name of Patient* Print Name of Caregiver/Authorized Pa Representative See next page to continue completing the Healthcar By signing, I agree to this agreement electronically with VyndaLink.	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 Test Test Test Test Print Name of Patient* Signa Print Name of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of By signing, I agree to this agreement, the <u>Consumer Disclosur</u> electronically with Vandal ink	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 Test Test Test Test Print Name of Patient* Print Name of Caregiver/Authorized Patient Representative See next page to continue completing the Healthcare Provider section of the Enrollment Form. By signing, I agree to this agreement, the Consumer Disclosure and to do business electronically with VyndaLink.



Introduction

Signing Up for the Provider Portal Setting Up Your Office



eSign via Email (cont'd)

Providers will receive a second email to review and sign

- To access the signature window, copy the password from the first email you received, then click **REVIEW and SIGN**.
- Click the yellow arrow **START** as in the first email, then type your 5 signature and click **APPLY**.
- Click each yellow **NEXT** arrow to populate the signature field. 6
- After the last **NEXT** arrow, click the blue button **CLICK to SIGN**, 7 which will show you a confirmation screen as in the first email signature process.



Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

Antion Antion 1					Enroll a
Filter By Clear Current Filters					
Office Names 💌	Provider 👻		Q. Search by Patie	ent First Name or Last Name or Pa	atient Id
Patient Name 1↓	Brand	Provider	Site	Ac	tions
Patient One P-00679634 12/12/1938	VYNDAMAX*	HANSA BHAYANI	GOLDEN_SITE_18		Unarchive
Patient Two P-00678148 12/24/1944	VYNDAMAX*	Henry Rollins	GOLDEN_SITE_1		Unarchive
Patient Three	VYNDAMAX*	Henry Rollins	GOLDEN_SITE_1	ſ	Unarchive
Connecting Access. Reinforzements, and Education					Messages My Team
Home Patient Enrollm	nent 🗸 My Cases My Patients R	esources Invite User			
nrollment Status	Pat	ient Information			
Reimbursement Support	Action Needed	tient One Pational Pation Pation	ent Id 00679634	Age 84 Years	Date of birth 12/12/1938
	Ma En	nail	ne Mobile		
	Pa	atient Address			
	Ad 12	Idress line 1 Add 3 Mozza Lane	Iress line 2	City NEW YORK	State NY
	10	012			
	Pa Pa	itient Contact itient Contact name Pati tient One Self	ient Contact Type	Primary Phone Type 	Patient Contact
	Clin	nical Information			
		ient Documents			
	Pat				
	Pat	ument ID	Туре	~	Upload Date



Introduction

Signing Up for the Provider Portal

Setting Up Your Office

ptions 🔻

Edit

~

Collapse All



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Viewing the Status of a Patient Enrollment

- Click the "My Patients" tab in the portal's navigation box. You will be redirected to the page listing all active patients.
- Click on a patient's name to go to that patient's Enrollment Status. 2
 - The "Enrollment Status" box on the upper-left corner shows the enrollment status for the requested support.



3

Note: To view one of the listed Patient Documents, click on that document's Document ID.



Note: If the support case has not been started, no status will be shown.

Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

	My Cases My Patient	s Resources	Invite User		
New Enrollment					
Incomplete Enrollment	:			Search	
				Search by Patient Name	
Patient Name	Service Requested		Started date	Last Modified Date	
Patient One	PAP		May 12, 2023, 09:09 AM EDT	May 12, 2023, 09:09 AM EDT	2
Patient Two	Reimbursement Support		May 10, 2023, 03:01 PM EDT	May 10, 2023, 03:01 PM EDT	
			May 10, 2023, 03:01 PM EDT	May 10, 2023, 03:01 PM EDT	
Patient Three	Reimbursement Support				
Patient Three Patient Four	Reimbursement Support		May 10, 2023, 10:08 AM EDT		
Patient Three Patient Four	Reimbursement Support		May 10, 2023, 10:08 AM EDT	May 12, 2023, 09:09 AM EDT	
Patient Three Patient Four	Reimbursement Support		May 10, 2023, 10:08 AM EDT	May 12, 2023, 09:09 AM EDT May 10, 2023, 03:01 PM EDT	Edit



dd a New Patient ovide Patient Demographic Information		
* Gender		
🔿 Male 🔿 Female		
* First Name	Middle Name	* Last Name
* Date of Birth		
MM/DD/YYYY	苗	
(If you are using internet Explorer, please type the date as MM/DD/YYYY in the field)		
* Address Line 1		



Signing Up for the Provider Portal



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Managing Incomplete Enrollments

Select "Incomplete Enrollments" from the Patient Enrollment tab. You will be redirected to all patients with incomplete enrollments.



Note: If you want to search for a patient on this page, use the search box and type in the patient's name.

- Click the arrow on the right of a patient's entry and select the "Edit" or 2 "Delete" option to edit or delete that entry.
- Once you have finished entering the patient's enrollment, click 3 complete and you will see the "Thank you" screen.

Enrolling Another Patient

- After submitting your first patient enrollment request, you will receive 4 a prompt stating that your patient's enrollment has been submitted.
- If you would like to enroll another patient at any time, hover over the 5 Patient Enrollment tab and click "New Enrollment."

Enrolling Patients

Managing Patient Cases

Managing Patient Cases in the Provider Dashboard



Introduction

Signing Up for the Provider Portal

Setting Up Your Office



Enrolling Patients

Managing Patient Cases eSignature Registration User Password Information

Patient Enrollment 🗸 My	Cases My Patients Resources Invit	te User		
y Cases				
ilter By Clear Current Filters				
Case Type	Provider Name	Status Brand	Office Name	s Case Completed Date
e	(If you are using Internet Explorer, please type the da	ate as MM/DD/YYYY in the field]		
Q Search by Case Number or Site of	or Patient Name or Patient Id			Action Needed OI In Progress
Patient Name 1	Brand Name	Case Type	Created Date 1	Status
testvyndalink, Pfizer 10/6/2004 PAT-46803915	VYNDAMAX®	Reimbursement Support 13804318	10/5/2021	😑 In Progress
Terms of Use	Privacy Policy	onic authorization to receive support from Windal ink. W	vndaLink offerings are available to reci	idents of the United States
Pfizer and Puerto Rico o	only. The product information provided in this sit	e is intended only for residents of the United States and	Puerto Rico. The products discussed r	nay have different product
labeling in differen	nt countries.			
labeling in differen				PP-VDM-USA-0563
issening in one e				PP-VDM-USA-0563
in the second				PP-VDM-USA-0563
				PP-VDM-USA-0563
VyndaLink 🖉				PP-VDM-USA-0563
				PP-VDM-USA-0563
Vyndalink Correcting in dirich ei	y Cases My Patients Resources Invite	e User		PP-VDM-USA-0563
Patient Enrollment V My	y Cases My Patients Resources Invite	e User		PP-VDM-USA-0563
Patient Enrollment My	y Cases My Patients Resources Invite	e User		PP-VDM-USA-0563
Patient Enrollment ∨ My Patient Name Option	y Cases My Patients Resources Invit	e User	Date of birth	PP-VDM-USA-0563
Patient Enrollment ∨ My Patient Name testvyndalink, Pfizer	Cases My Patients Resources Invite Patient Id PAT-45803915	e User Age 16 Years	Date of birth 10/6/2004	PP-VDM-USA-0563
My Cases Patient Name testvyndalink, Pfizer Mobile (234) 567-8908	Y Cases My Patients Resources Invite Patient Id PAT-45803915 Email padmini.mishra2@test.com	e User Age 16 Years	Date of birth 10/6/2004	PP-VDM-USA-0563
Patient Enrollment V M Patient Name testvyndalink, Pfizer Mobile (234) 567-8908	Cases My Patients Resources Invite Patient Id PAT-46803915 Email padmini.mishra2@test.com	e User Age 16 Years	Date of birth 10/6/2004	PP-VDM-USA-0563
Patient Enrollment ∨ M Patient Name testvyndalink, Pfizer (234) 567-8908	Cases My Patients Resources Invite Patient Id PAT-45803915 Email padmini.mishra2@test.com	e User Age 16 Years	Date of birth 10/6/2004	PP-VDM-USA-0563
Patient Enrollment ∨ M Patient Name testvyndalink, Pfizer (234) 567-8908	✓ Cases My Patients Resources Invite Patient Id PAT-45803915 Email padmini.mishra2@test.com	e User Age 16 Years	Date of birth 10/6/2004	PP-VDM-USA-0563
Patient Enrollment ∨ M My Cases Patient Name testvyndalink, Pfizer Mobile (234) 567-8908	Cases My Patients Resources Invite Patient Id PAT-45803915 Email padmini.mishra2@test.com	e User Age 16 Years	Date of birth 10/6/2004	PP-VDM-USA-0563
Case Information	✓ Cases My Patients Resources Invite Patient Id PAT-45803915 Email padmini.mishra2@test.com	e User Age 16 Years	Date of birth 10/6/2004	PP-VDM-USA-0563
Patient Enrollment V My Patient Name testvyndalink, Pfizer (234) 567-8908 Case Information	Cases My Patients Resources Invite Patient Id PAT-45803915 Email padmini.mishra2@test.com Collec	e User Age 16 Years	Date of birth 10/6/2004	PP-VDM-USA-0563 Messages My Team My Approvers Mome Telephone (234) 567-8905 Completed — Col
Patient Enrollment V My Patient Name testvyndalink, Pfizer (234) 567-8908 Case Information Case Type Reimbursement Support	V Cases My Patients Resources Invita Patient Id PAT-46803915 Email padmini.mishra2@test.com Collect Collect Case Sub Type New BV	e User Age 16 Years t / Validate Benefits Details	Date of birth 10/6/2004	PP-VDM-USA-0563
Patient Enrollment V M Patient Name testvyndalink, Pfizer (234) 567-8908 Case Information Case Type Reimbursement Support	V Cases My Patients Resources Invite Patient Id PAT-45803915 Email padmini.mishra2@test.com Collect Case Sub Type New BV	e User Age 16 Years t / Validate Benefits Details	Date of birth 10/6/2004	PP-VDM-USA-0563



Introduction

Signing Up for the Provider Portal Setting Up Your Office For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Reviewing Cases for Patients

To view a list of all your patient's cases, click "My Cases" on the navigation bar. To quickly view cases needing action, scroll down on the home page to the "Cases Need Action" box and select "View Cases."



Note: If you have at least one patient enrolled, your home page will appear similar to the following example showing a diagram of cases requiring action.

- Click the Patient Name of the case you want to view. It will go to the 2 Case page where you can view Patient Information, Case Information, Related Cases, and Patient Documents.
- Under Patient Information, you will see a task bar showing that case's 3 status and any actions you may need to take.



Note: You can set up email notifications on case activity by following instructions on page 7.

Enrolling Patients

Managing **Patient Cases**

eSignature Registration User Password Information

My Patients	ses My Patients Resources Invite U	5561		Enroll a New Pat
Active <u>Archived</u>				
Filter By Clear Current Filters				
Office Names 💌	Provider 🔻		Q Search by Patient First Name or Last Name or Patient Id	
Patient Name ↑	Brand	Provider	Site Actions	
Patient One P-00679634 12/12/1938	VYNDAMAX®	HANSA BHAYANI	GOLDEN_SITE_18	
Patient Two P-00678148 12/24/1944	VYNDAMAX*	Henry Rolli	Archive the Patient	
Patient Three	VYNDAMAX®	Henry Rolli You are abou	t to archive Patient One	
		Please provid	le the reason below:	
		3 Select Reas	on	
				Cancel
Vundal ink				Pfizer tes
WORKERSE Home Patient Enrollment 、 My Case	ses My Patients Resources Invite U	Jser	Messages My Team My Approv	Pfizer tes vers
Mome Patient Enrollment V My Cast My Patients	ses My Patients Resources Invite U	Jser	Messages My Team My Approv	Pfizer tes vers Enroll a New Pat
Mome Patient Enrollment V My Case My Patients Active Active Active	ses My Patients Resources Invite U	Jser	Image: Second state Image: Second state Messages My Team My Approv	Pfizer tes vers Enroll a New Pat
Nome Patient Enrollment V My Case My Patients Active Archived Active Archived Active Archived Filter By Clear Current Filters	ses My Patients Resources Invite U	Jser	Image: Second state Image: Second state Messages MyTeam MyApprov	Pfizer tes vers Enroll a New Pat
Nome Patient Enrollment V My Cas My Patients Active Archived Active Archived Iter By Clear Current Filters	ses My Patients Resources Invite U	Jser	Messages My Team My Approv	Pfizer tes vers Enroll a New Pat
Nome Patient Enrollment V My Case My Patients Active Active Filter By Clear Current Filters Office Names Patient Name 14	ses My Patients Resources Invite U Provider	Jser	Messages My Team My Approv Image: Control of the state of	Pfizer tes vers Enroll a New Pat
Nome Patient Enrollment V My Cas My Patients Active Archived Active Archived Iter By Clear Current Filters Office Names 1 Patient Name 1 Patient One P-00679634 12/12/1938	ses My Patients Resources Invite U Provider Provider Brand VYNDAMAX*	Diser Provider HANSA BHAYANI	Messages My Team My Approv My Search by Patient First Name or Last Name or Patient Id Site Actions GOLDEN_SITE_18	Pfizer tes vers
Nome Patient Enrollment V My Case My Patients Active Actived Active Actived Active Actived Iter By Clear Current Filters Office Names Patient Name 1 Patient One P-00679634 12/12/1938	ses My Patients Resources Invite U Provider Provider Brand VYNDAMAX*	Jser Provider HANSA BHAYANI Henry	Image: Researce Message My Team My Team <td>Pfizer tes vers Enroll a New Pat</td>	Pfizer tes vers Enroll a New Pat
Nome Patient Enrollment V My Case My Patients Active Archived Active Archived Jetter By Clear Current Filters Patient Name 1 Patient Name 1 Patient One P-00579634 12/12/1938	ses My Patients Resources Invite U Provider Provider Brand VYNDAMAX® VYNDAMAX®	Jser Provider HANSA BHAYANI Henry You are about to	Image: Reside of the second secon	Pfizer tes vers
Nome Patient Enrollment V My Case My Patients Active Archived Active Archived Office Names Patient Name 1 Patient One P-00679634 12/12/1938	ses My Patients Resources Invite U Provider Provider Brand VYNDAMAX®	Jser Provider HANSA BHAYANI Henry You are about to	Interview Patient One	Pfizer tes vers Enroll a New Pat
Image: Constraint of the second s	ses My Patients Resources Invite U Provider Provider Brand VYNDAMAX* SSS! NUMBAMAX*	Jser Provider HANSA BHAYANI Henry You are about to	Resards With an Article Resards With an Article Resards Market or Patient Id Site Actions COLDEN_SITE_18 COLDEN_SITE_18 Unarchive Patient One Unarchive Patient One	Pfizer tes vers Enroll a New Pat



Archiving and Unarchiving Patients

Archiving Patients

- Click the "My Patients" tab on the portal's navigation panel. Under the "Active" section, you will see a list of all active patients.
- Click the "Archive" box for the patient you want to archive.
- Select the reason, then press "Archive." The patient's information will 3 no longer appear on the "Active" section.

Unarchiving Patients

- Click the "Archived" tab on the "My Patients" page to view all archived patients. Find the patient entry for the patient you want to unarchive.
- Under the Actions section of the patient's entry, click "Unarchive." 2 Press "Unarchive" on the pop-up box. The patient's information will no longer appear in the Archived section.

Up office

Enrolling Patients

Managing **Patient Cases**

eSignature Registration **User Password** Information

lome	Patient Enrollment 🗸	My Cases	My Patients	Resources	Invite User	
Welc	ome, Healthcare Provider					
The V your	VyndaLink Provider Portal is a objective.	n efficient tool	created for healt	hcare profession	nals and their office stat	ff to enroll and manage their patient
Electro	onic Services					
		Vy	ndaLink ల Excarge Jacobs Reserver, 1997 December			
ef	PA	Hom	ne – Patient Enrollment 🗸 – M	Ay Cases My Patients Re	sources Invite User	
R/ fo	equest Electronic Prior Author or the prescribed patient there	rization apy	Electronic	Prior Autho	rization	
				P	ease fill out the required information belo	ow to continue with electronic prior authorization
3	Start ePA		2	*Select the office where the patie	nt is being seen.	Select the patients prescribing physician. Search provider.
				Please select the patient you are Search nation	submitting a request for:	Please select the payer the prior authorization is being submitted to. Search yeaver
		_		Please select one product being	prescribed to this patient.	of pearty baker.
				(
				Q Search product.		
				Q Search product. Note: You v Please disa	vill be redirected to an external platform ble your popup blocker.	to continue with the electronic prior authorization process.
/yn	daLink 💉			Q Search product. Note: You v Please disa Back	vill be redirected to an external platform ble your popup blocker.	to continue with the electronic prior authorization process.
/yn Reimburse	Connecting Access, ement, and Education			Q. Search product. Note: You v Please disa Back	vill be redirected to an external platform ble your popup blocker.	to continue with the electronic prior authorization process.
Jyn Reimburse Authorization	Connecting Access, ement, and Education	bmission		Q, Search product. Note: You v Please disa Back	vill be redirected to an external platform ble your popup blocker.	to continue with the electronic prior authorization process.
/yn Reimburse Authorizaban	Connecting Access, ement, and Education Prior Authorization Sul Prior Authorization Sul Send a Case Link	bmission us: Created		Q. Search product. Note: You V Please disa	vill be redirected to an external platform ble your popup blocker.	to continue with the electronic prior authorization process.
Authorization	Connecting Access, ement, and Education Prior Authorization Sul Prior Authorization Sul Send a Case Link Patient	bmission ws: Created		Q. Search product. Note: You N Please disa	vill be redirected to an external platform ble your popup blocker.	to continue with the electronic prior authorization process.
Authorization	Connecting Access, ement, and Education Prior Authorization Sul Prior Authorization Sul Send a Case Link Patient Patient Gender: Male DOB: 04/21/2000	bmission us: Created		Q. Search product.	vill be redirected to an external platform to ble your popup blocker.	to continue with the electronic prior authorization process.
Authorization	Connecting Access, ement, and Education Prior Authorization Sul Prior Authorization Sul Prior Authorization Sul Send a Case Link Patient Patient Patient epa summer Gender: Male DOB: 04/21/2000	bmission us: Created		Q. Search product.	vill be redirected to an external platform of ble your popup blocker.	to continue with the electronic prior authorization process.
Authorization	Connecting Access, ement, and Education Prior Authorization Sul Prior Authorization Sul Send a Case Link Patient Patient DOB: 04/21/2000 Prescriber Name: Pf2er ptotwo NBP: 2245655002	bmission ws: Created		Q Search product.	vill be redirected to an external platform to ble your popup blocker.	to continue with the electronic prior authorization process.
/yn Reimburse	Connecting Access, ement, and Education Prior Authorization Sul Prior Authorization Sul Prior Authorization Sul Send a Case Link Patient Patient Patient epa summer Gender: Male DOB: 04/21/2000 Prescriber Name: Pf2er protwo NPI: 2345657987 Phone: 23456578987	bmission us: Created		Q. Search product.	vill be redirected to an external platform to ble your popup blocker.	to continue with the electronic prior authorization process.
Authorization	Connecting Access, ement, and Education Prior Authorization Sul Prior Authorization Sul Prior Authorization Sul Send a Case Link Patient Patient Patient Cender: Male DOB: 04/21/2000 Prescriber Name: Pf2er protwo NPI: 2345657987 Phone: 234567987	bmission us: Created		Q. Search product.	vill be redirected to an external platform to ble your popup blocker.	to continue with the electronic prior authorization process.
Authorizaban	Connecting Access, ement, and Education Prior Authorization Sufficient Send a Case Link Patient Patien	bmission us: Created (3)	E, LIQUID FILLED (0069873030	Q. Search product. Note: You Y Please disa Back	vill be redirected to an external platform to ble your popup blocker.	to continue with the electronic prior authorization process.
Authorization	Connecting Access, ement, and Education Prior Authorization Sutters Prior Authorization Sutters Send a Case Link Patient Patient: Patient: Connecting Access, ement, and Education Prior Authorization Sutters Send a Case Link Patient:	bmission us: Created (Cartana ax) 61 mg/1 ORAL CAPSUL	E, LIQUID FILLED (0069-873030	Q. Search product. Note: You N Please disa Back	vill be redirected to an external platform to ble your popup blocker.	to continue with the electronic prior authorization process.
Authorization	Connecting Access, ement, and Education Prior Authorization Sub Prior Authorization Sub Send a Case Link Patient Patient epa summer Gender: Male DOB: 04/21/2000 Prescriber Name: Pf2er protwo NPI: 2345657987 Phone: 2345679897 Drug: Ta famidis (V)ndam ND C: 0006987 3030	bmission us: Created hax) 61 mg/1 ORAL CAPSUL tion	E, LIQUID FILLED (0069.873030	Q Search product.	vill be redirected to an external platform to ble your popup blocker.	to continue with the electronic prior authorization process.
Authorization	Connecting Access, ement, and Education Prior Authorization Sul Prior Authorization Sul Send a Case Link Patient Patient epa summer Gender: Male DOB: 04/21/2000 Prescriber Name: Pf2er protwo NPI: 2345657987 Phone: 2345657987 Phone: 2345678987 Drug Drug: Tatamidis (V)ndam ND C: 0006987 3030	bmission us: Created tax) 61 mg/1 ORAL CAPSUL tion Aethor prigate form. If no form is four	E, LIQUID FILLED (0069.873030 a nd, please revert to the manual pro	Q Search product.	vill be redirected to an external platform to ble your popup blocker.	to continue with the electronic prior authorization process.



Introduction

Signing Up for the Provider Portal Setting Up Your Office



Creating Electronic Prior Authorizations (ePA)

- Navigate to the portal's home page. Under the "Electronic Services" heading, click "Start ePA."
- Complete required fields, then press "Continue." 2



Alert: The patient must first be enrolled and found in the Provider Portal before submitting an ePA for the patient.

- In the Prior Authorization platform, you will see that the prior 3 authorization status is marked as "Created" and you will have the option to send a case link.
 - Under Payer PA Form Selection, select the payer. Then, select the appropriate form from the list.



Note: If no form is found, please revert to the manual process.



Click "Next Step."

Enrolling Patients

Managing **Patient Cases**

eSignature Registration User Password Information

		Welcome Pfizer protive
or Authorization	Prior Authorization Sulemission	
	Prior Authorization Status: Open	
6	Sehetate PDF Cance Fax PA Form Send a Case Link	Octoreb
	Sent Called Number	Status
	Patient	Colleg
	Patient: epa summer	Address: New yerk
	Gender: Male DOB: 04/21/2000	City, State Zip: ACKWORTH, IA 50001 Primary Phone:
	Prescriber	Collap
	Name: Pilzer protwo NPI: 2345657987	Address: Caliofnia City, State ZIP: STEPHENSPORT KY 40170
	Phone: 2345678987	Fax: 4567898645
	Drug	
	Drug: Tafamidis (Vyndamax) 61 mg/1 ORAL CAPSULE, LIQUID FILLED (0069-873030) NDC: 00069873030	Days Supply: Quantity: 1 Carten
	Questions & Answers	
	Prior Authorization Request	
	What are the directions for use?	
	What is the diagnosis?	
	What is the ICD Code?	
	What is the expected length of therapy?	
	Is this request for a continuation of therapy? Ves No	
	Sussedies Information	
	Selart a file	Chanse Bemore
	Please uplead any supporting documentation that you believe may help the Payer evaluate your case. Th Policy) Permitted formats are PDF. PNG, and TJFF.	is may include Medical Records. Letter of Medical Necessity. Previous Communication from Payer (e.g., Denials, Approvals, or Medical
	Signature	
•	Please include a signature to complete the pa	
	Sign above Clear Save Cancel	
	Sign	
	Save Provress Submit	



Introduction

Signing Up for the Provider Portal Setting Up Your Office



Creating Electronic Prior Authorizations (ePA) (cont'd)

After clicking "Next Step," the Prior Authorization Status will be 6 marked as "Open." Click the appropriate button to generate a PDF.



Note: You can see the status of any fax sent in the Prior Authorization Submission section.

- Fill out the Questions and Answers section with the patient's information. Under the Supporting Information section, upload any documents with supporting information to help the payer evaluate your case.
- Click "Sign" to electronically sign the form. Press "Submit."
- After submitting the PA request, you will be redirected to the patient's case page. When the prior authorization is completed, you will see its status updated on this page.

Enrolling Patients

Managing **Patient Cases**

eSignature Registration **User Password** Information

папк уоц	for submitting your enrollment request:
Pharmacy: V	YNDAMAX
	ebytest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC
	Your patient may pay as little as 20%. For an annual max of up to \$40000
6.75	Please click on your Case to see additional details about your patient's coverage.
you would like ate that the ca	e to view the status of the enrollment, please navigate to the Case List View . Plea se(s) you just created may take several minutes to appear on your list.
you would like	to onroll another patient, click here.
	ی بنی View and Download Forollesent Form
ources Inviti	e User
ources Invito	e User
wrces Invite 'hank you	for submitting your enrollment request!
wrces Invite	• User for submitting your enrollment request!
hank you	for submitting your enrollment request!
hank you	for submitting your enrollment request! YNDAMAX ebytest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC
hank you	e User for submitting your enrollment request! YNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA)
hank you	e User for submitting your enrollment request! /YNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA)
hank you	e User for submitting your enrollment request! YNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA) Click below to start the ePA process.
hank you	e User for submitting your enrollment request! YNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA) Click below to start the ePA process. ePA
hank you Pharmacy: V	e User for submitting your enrollment request! MNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA) Click below to start the ePA process.
hank you	e User for submitting your enrollment request! MNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA) Click below to start the ePA process.
hank you Pharmacy: V	e User for submitting your enrollment request! YNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA) Click below to start the ePA process. ePA Please click on your Case to see additional details about your patient's coverage.
vinces Invite hank you Pharmacy: V	e User for submitting your enrollment request! YNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA) Click below to start the ePA process. ePA Please click on your Case to see additional details about your patient's coverage. to view the status of the enrollment, please navigate to the Case List View. Please se(s) you just created may take several minutes to appear on your list.
vou would like	e User for submitting your enrollment request! YNDAMAX ebvtest Vyndalink is covered by CIGNA PHARMACY SVCS UNSPEC with a prior authorization (ePA) Click below to start the ePA process. ePA Please click on your Case to see additional details about your patient's coverage. to view the status of the enrollment, please navigate to the Case List View. Please se(s) you just created may take several minutes to appear on your list. to enroll another patient, click here.



Introduction

Signing Up for the Provider Portal Setting Up Your Office





Understanding Electronic Benefits Verification (eBV) Outcomes

Once the eBV process has been completed for a patient, you will receive messages telling you the eBV results.

- **Message 1:** Patient is Covered–If the patient's medical treatment is covered by their payer's plan, you will receive a message showing the percentage the patient may pay for the treatment and their annual maximum coverage for that treatment. If the patient's pharmacy treatment is covered, you will receive an equivalent message.
- **Message 2:** Patient is covered with an ePA-If the patient's medical 2 or pharmacy treatment is covered with a prior authorization, you will receive the following message. To start the ePA process, click the "ePA" button.

Enrolling Patients

Managing **Patient Cases**

eSignature Registration **User Password** Information

		Messages My Team	My Approvers
Home Patient Enrollment 🗸 My Cases M	ly Patients Resources Invite User		
Secure Messaging			
Inbox Archive		New Secure Message	
	150	New Secure Message	
+ New Secure Message	* Is this Patient or Site Message?		
	3		
	* Subject		
	* Message		
	Attachments		
	*Allowed file types: .gif,.png,.docx,.doc,.pdf,.bm *Maximum file size: 4.5 MB	p,.xlsx,.xls,.txt,.jpg,.tiff,.tif	
	*Maximum number of files: 5		
	A Unload Files Or dree files		
			Ca
Secure Messaging			
Inbex Archive			
Inbex Archive 6			- Cel
Inbex Archive 6			— Cel
Inbex Archive 6			— Ceit
hbex Ardive 6 + New Secure Message Santhosh, Provider - test message	ge (0) - 0 day(s) ago		— Celt
hbex Ardive 6	ge (0) - 0 day(s) ago	Mark as Read Multi- Ulinteral	- Cei
+ New Secure Message Santhosh, Provider - test message Participant(s): Santhosh, Provider	ge (0) - 0 day(s) ago	Mark as Read 📓 Mark at Linnaud	- Cei
hbex Archive Archive Archive Archive Mew Secure Message Santhosh, Provider - test message Participant(s): Santhosh, Provider Brand: VYNDAMAX Program: VyndaLink Patient:	ge (0) - 0 day(s) ago	Mark as Read 🜌 Mark as Inneud	- Cel
Archive A	ge (0) - 0 day(s) ago	Mark as Read 💌 Mark at Illinaad	Archive 4
Index Archive Image: Market State Image: Market State Image: Market State Santhosh, Provider - test message Image: Market State Santhosh, Provider - test message Image: Market State Site: Test Site Subject: test message Image: From From	ge (0) - 0 day(s) ago	Mark as Read Submitted	Archive
Inbex Archive Image: Participant(s): Santhosh, Provider - test message Santhosh, Provider - test message Brand: VYNDAMAX Program: Vynolalink Patient: Site: Site: Test Site Subject: test message Image: Prom Provider Test	ge (0) - 0 day(s) ago	Submitted Image: Control of the second se	Archive Archive View View Deta
Index Archive Image: Mean of the second descent frequency of the second descen	ge (0) - 0 day(s) ago	Mark as Read Mark and Mark as Read Submitted 0 Thursalay, April 22, 2021, 06:35 PM	Archive View View Deta
Index Archive Image: New Secure Message Image: New Secure Message Santhosh, Provider - test message Participant(s): Santhosh, Provider - test message Brand: VYNDAMAX Program: Vynolalink Patient: Site: Test Site Subject: test message Image: Provider Test Santhosh, Provider - Message test	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago	Submitted Image: Submitted 1	Archive Archive View View
Index Archive Image: Participant(s): Santhosh, Provider - test message Brand: VYNDAMAX Program: Vynelalink Patient: Site: Site: Test Site Subject: test message Image: Provider Test Provider Test Santhosh, Provider - Message test	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago	Mark as Read Landow and American Ameri American American	Archive View View Eachive Archive
Index Archive Image: New Secure Message Santhosh, Provider - test message Participant(s): Santhosh, Provider - test message Brand: VYNDAMAX Program: Vynolalink Patient: Site: Test Site Subject: test message Image: Prowider Test Santhosh, Provider - Message test	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago	Mark as Read Mark as Read Submitted 0 Thurselay, April 22, 2021. 06:35 PM	Archive View View View Eta
Index Archive Image: Archive Image: Archive </td <td>ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago</td> <td>Mark as Read Submitted 0 Thursalay, April 22, 2021, 06:35 PM</td> <td> Ceil Archive View View Detail Archive Archive </td>	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago	Mark as Read Submitted 0 Thursalay, April 22, 2021, 06:35 PM	 Ceil Archive View View Detail Archive Archive
Inbex Archive Image: New Secure Message Santhosh, Provider - test message Participant(s): Santhosh, Provider - test message Program: VYNDAMAX Program: Vynolalink Patient: Site: Test Site Subject: test message From Previder Test Santhosh, Provider - Message test Santhosh, Provider - Message test	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago	Mark as Read M	Archive Archive Arc
Inbex Ardive Imbex Ardive Imbex Ardive Imbex Participant(s): Santhosh, Provider - test message Brand: VYNDAMAX Program: VyndaLink Patient: Site: Site: Test Site Subject: test message Image: Prowider Test Santhosh, Provider - Message test Santhosh, Provider - Message test Santhosh, Provider - Message test	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago est (0) - 6 day(s) ago	Mink as Read M	Archive Archive View View Eta Archive Move thread to
Index Archive Image: New Secure Message Image: New Secure Message Santhosh, Provider - test message Image: New Secure Messag	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago est (0) - 6 day(s) ago	Mark as Read Mark as Read Mark as Read Submitted 1 Thursalay, April 22, 2021, 06:35 PM	Archive View View Eta
Archive A	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago	Mark as Read M	Archive Archive Archive Archive Move thread to
Archive Santhosh, Provider - test message Archive	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago	Mark as Read Submitted 0 Thursday, April 22, 2021, 06:95 PM	Archive Archi
Archive A	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago est (0) - 6 day(s) ago X Message V Attachments	Mark as Read Submitted 0 Thursalay, April 22, 2021, 06:35 PM	Archive Archive Archive Move thread to View
Inbex Archive	ge (0) - 0 day(s) ago V Message V Attachments Test est (0) - 13 day(s) ago est (0) - 6 day(s) ago V Message V Attachments ypkinabdhp gagprizmzy	Mark & Read Submitted Image: Submitted Image: Submitted </td <td>Archive Archive View View View</td>	Archive Archive View View View

Introduction



Signing Up for the Provider Portal Setting Up Your Office



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Using Secure Messaging

- Click the "Messages" icon to go to the Secure Messaging page.
- Click "+ New Secure Message" to create a new message.
- 3 Answer the question "Is this a Patient or Site Message?" Type in the message's subject line and message body and attach any documents.
- Confirm that you have obtained authorization from the patient for the 4 disclosure of their information, then press "Send."



Note: In your inbox, messages will appear similar to the following example. Click "View Details" to see that message's details.

- To reply to a message, click the "Reply" button. Click the "Archive" 5 button on the message's upper-right hand corner to archive a message. The message will no longer appear in your inbox.
- To unarchive a message, click the "Archive" tab. You will be able to 6 view all archived messages on this page.
- Click the "Move thread to Inbox" button on the message you want 7 to unarchive.

Enrolling Patients

Managing **Patient Cases**

VyndaLink Ø			0		Messages My Te	am My Approvars	Pfizer tester
Home Proliment	✓ My Cases	My Patients	Resources	Invite User			
FAQ Library Support							
Name					Action		





Introduction

Signing Up for the Provider Portal

Setting Up Your Office



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

Navigating the Portal Resources Page

Click the "Resources" tab on the portal's navigation panel to access several resources helpful to accomplishing tasks on the portal, such as FAQs, Library, and Support.



Note: See the FAQs at tab below.

- Click the "Library" tab to access forms for this program. Click the 2 "Download" button to download that form.
- Click the "Support" tab to access VyndaLink's contact information. 3

Enrolling Patients

Managing **Patient Cases**

eSignature Registration User Password Information





Introduction

Signing Up for the Provider Portal

Setting Up Your Office



eSignature Registration

Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information

eSignature Registration

	Register for eSignature You are being redirected to SmartID, in order to be app
Pfizer has partnered wit	th Smart ID Network to support electronic physician signature (eSignature) authorization.
	Register for eSignature
Note: Re	gistration form opens in a new popup. Please disable your popup blocker.
Title	MD PhD DMD DO DDS DVM DPM PN oto
First Name:	Robert
Middle Initial:	
Last Name:	Smith
Suffix:	Sr, Jr, III
Practice Name:	
Practice Management System: Practice Address:	Select one pick "Other" if not on list
Practice Address 2:	
Practice City:	
Practice State:	Select a State V
Practice Zip:	
Practice Phone:	
Email Address:	
Confirm Email Address:	
Primary Specialty:	Select a Primary Specialty
Secondary Specialty:	Select a Secondary Specialty
Prescribing Rights:	Prescriber T
Username:	
Confirm Password:	is case sensitive
Select a Secret Question:	Select a Security Question
Secret Question Answer:	
Birth Year:	(YYYY)
Last 4 of SSN:	
NPI:	1029384756
State License Number:	Select State License T
State License Expiration Date:	mm/dd/yy
DEA#:	
DEA Expiration Date:	mm/dd/yy
DEA Schedule:	
	Submit 4
Request to Authorize eSignature for use with the VyndaLink Prov	ider Portal
Smart ID Works <jdaly@smartidworks.com> To ● Robert Smith Retention Policy Inbox (1 year 6 monthe)</jdaly@smartidworks.com>	Seeply Seeply Forward *** Fri 04/02/2021 4:18 PM Fri 04/02/2021 4:18 PM Fri 04/02/2021 4:18 PM Fri 04/02/2021 4:18 PM
Attachments	+ Get more add.ins
Dear Provider Test, : Thank you for registering, to use your esignature with the VyndaLink Provider Portal. To com-	nplete this process, please log into web site using your DEA number, the last four digits of your social security number and the answer to the secret question you
established on your registration form. This verification step provides VyndaLink Provider Por To complete the verification step, please click <u>here.</u> If you are unable to click on this link, ple	tai with your authorization to use your esignature for the VyndaLink Provider Portal. ase copy and paste this URL into your internet browser address https://providerportal.sidw.local/erxga/pp-reg.aspx?u=d5451786-9d5d-43ed-b54a-
causeoutori=30487/88=8001-3040-8020-8024/40017189&t=b035c795-3e28-417F-844c-5 8475&ui=1179&sf=a2V2C0000006SuIUAE	
once you nave successfully completed the ventication step, you and/or your designated and the specific delegate who attached and submitted the enrollment (e.g., "Authorized by Susa If you chose not to allow delegates to apply your estimative during the context of the second states	a durunized unice start (i.e., your deregates) will be able to apply your esignature to online enrollments for VyndaLink Provider Portal. The esignature will reflect n Smith, RN, on behalf of Dr. Jane Doe on January 1, 2008, at 3:00 pm ET").
If you show that you arrow weingates to apply your esignature during the registration process, enrollments and apply your esignature on your behalf if doing so would violate your state? If you have any questions about the esignature process, or wish to choose your esignature.	stress only you will be also a source action your expensive to vyrindelink provider portal enrollinents, rou must not elect to authorize delegates to submit online (s pharmacy laws, You are solely responsible for determining whether delegates are allowed under your state's pharmacy laws. election for either participation and/or delegate authorization, please call the Vondal ink Provider Portal at (888) 272-8475
Thank you!	
Sincerely,	

Introduction

Signing Up for the Provider Portal Setting Up Your Office For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)



Providers have the option of using our eSignature system to electronically submit valid prescriptions. To use this system, the provider must complete the Smart ID eSignature registration and verify the provider as an authorized prescriber. This is a separate registration than the portal.

Click the "eSignature" tab, then click the "Register for eSignature" button. A prompt redirecting you to SmartID will pop up.



Alert: The registration form opens in a new pop-up box. Please disable your pop-up blocker before continuing.

- Click "Proceed." A new tab will open on your browser.
- Fill out the SmartID form on the new tab. Required field boxes are yellow 3 and optional field boxes are white.
- Press "Submit." You will then see a Pending Verification page. 4
- You will then receive an email with directions and a link to complete the 5 validation process. The link in the email will trigger the final validation step where you will need to enter your DEA number, the last 4 numbers of your SSN, the answer to your secret question, and then select "Complete."

If the information submitted in the final validation step matches what was submitted in the eSignature form, you will receive a "Congratulations" message. If the information does not you will receive an error message.

Managing Patient Cases

eSignature **Registration**

User Password Information





Introduction

Signing Up for the Provider Portal

Setting Up Your Office



User Password Information

Enrolling Patients

Managing Patient Cases

eSignature Registration **User Password** Information

FAQs and Troubleshooting

33

User Password Information

<pre>prove prove p</pre>	Automatication Automatication Automatication Autom	Rentement of finance	lease enter your email and password. If you don't have a logi click Sign Up. Log In Here
 Log In Here Use finite being being	 Image: Contract of the set of the set of the device of the		Log In Here
VirdaLink helps eligible patients connect to access and affordability support, and find educational resources to help them with treatment journey with VYNDAMAX [*] . CURSERVICES OUR SERVICES Patient Enrollments Patient Enrollments Patient Management Contract VS	Virdulink helps eligible patients connect to access and affordability support, and find educational resources to help them with their treatment journey with VMDAMAX*. Interactive patients connect to access and affordability support, and find educational resources to help them with their treatment journey with VMDAMAX*. Interactive patients connect to access and affordability support, and find educational resources to help them with their treatment journey with VMDAMAX*. Interactive patients connect to access and affordability support, and find educational resources to help them with their treatment journey with VMDAMAX*. Interactive patients connect to access and affordability support, and find educational resources to help them with their treatment journey with VMDAMAX*. Interactive patients connect to access and affordability support, and find educational resources to help them with their treatment journey with VMDAMAX*. Interactive patients find find their treatment interactive patients. Interactive patients. Interactinte patients. Interactive		
AyndaLink helps eligible patients connect to access and affordability support, and find educational resources to help them with their treatment journey with VNNDAMAX.	Apprediation helps eligible patients connect to access and affordability support, and find educational resources to help them their treatment journey with VYNDAMAX*. Inter treatment journey with VYNDAMA*. Inter treatment journey with VYNDAMAX*. Inter treatment journey with VYNDAMA*. Inter treatment journey trea		User Email
their treatment journey with VYNDAMAX*. Important Safety information Patient Enrollments Patient Management Corrison Electronic Services Important Safety information Read More Important Prescribing Information Read More Read More Read More Corrison More Corrison Corrison	Intertretement journey with VYNDAMA*. Image: Second	VyndaLink helps eligible patients connect to access and affordability support, and find educational resources to help them with	Password Forgot your password?
	<text><text><text><section-header><complex-block><section-header>be and the series of the</section-header></complex-block></section-header></text></text></text>	their treatment journey with VYNDAMAX [®] .	Remember Me
Prese protect your login credentials. Do not share your username or password. OUR SERVICES Interactive Dashboard	Interactive Cashoor Ca		Log In
OUR SERVICES Important Safety Information Read More Terractive Dashboard Important Safety Information Read More See Full Prescribing Information Read More Definition CONTACT US	<image/> OUR SERVICES Image: Services		Please protect your login credentials. Do not share your username or password.
Interactive Dashboard Important Sefety Information Read More Important Prescribing Information Read More See Full Prescribing Information CONTACT US	<image/> <image/> <complex-block><complex-block><complex-block><complex-block></complex-block></complex-block></complex-block></complex-block>	OUR SERVICES	
VyndaLink Address: PO Box 221296 Charlotte, NC 28222 Phone: (888) 222 - 8475 Fax: (888) 878 - 8474 Hours: Monday - Friday, 8am EST - 8pm EST	VyndaLink Address: PO Box 221296 Charlotte, NC 28222 Phone: (888) 222 - 8475 Fax: (888) 878 - 8474 Hours: Monday - Friday, 8am EST - 8pm EST	Important Safety Information Important Prescribing Information Read More See Full Prescribing Information including Patient Information Click h	Patient Enrollment Form sere to download the Pfizer VyndaLink Enrollment Form
VyndaLink PO Box 221296 Address: PO Box 221296 Charlotte, NC 28222 Charlotte, NC 28222 Phone: (888) 222 - 8475 Fax: (888) 878 - 8474 Hours: Monday - Friday, 8am EST - 8pm EST	VyndaLinkPO Box 221296 Charlotte, NC 28222Phone:(888) 222 - 8475Fax:(888) 878 - 8474Hours:Monday - Friday, 8am EST - 8pm EST	CONTACT US	
Honday Hiddy daily control		VyndaLink PO Box 221296 Address: PO Box 221296 Charlotte, NC 28222 Phone: (888) 222 - 8475 Fax: (888) 878 - 8474 Hours: Mondays & FST - 8pm FST	



Introduction

Signing Up for the Provider Portal Setting Up Your Office



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)



Alert: The user's password expires every 120 days. You must change your password when seeing the prompt "Change Password" or receiving the "Change Password" email. You will be locked out of the portal if the password is not changed within the time frame. If you do not remember your security words, you will need to call portal technical support to have it unlocked.

Forgot Password? Reset



Click "Forgot your password?" in the Login box to go to the "Forgot" 2 Password?" page. Enter your user email to receive an email with instructions on how to reset your password. You must take action within 24 hours of receiving the email.



Note: See FAQs and Troubleshooting for tips.

Managing Patient Cases

eSignature Registration **User Password** Information





Introduction

Signing Up for the Provider Portal

Setting Up Your Office



FAQs and Troubleshooting

Enrolling Patients

Managing Patient Cases

eSignature Registration User Password Information



Who at my site will have access to my patient's records?

Only users who have been approved for the patient's office affiliation will be able to view the patient-specific information. All users must be approved for their office affiliation by the Office Administrator before seeing patient data.



How can I reset my password?

Navigate to your name in the upper right-hand corner of the Provider Portal. Select **Profile** from the drop-down list. From your profile, click the **My Information** section and select **Change Password**. Your new password must contain the following: • 8 or more characters • 1 uppercase letter • 1 lowercase letter • 1 numeric or 1 non-alphanumeric character

How do I update my email notification preferences?

Navigate to your name in the upper right-hand corner of the Provider Portal. Select **Profile** from the drop-down list. From your profile, click the **Email Notifications** section. Select the email notifications you would like to receive.

How do I request a new office affiliation?

Navigate to your name in the upper right-hand corner of the Provider Portal. Select **Profile** from the drop-down list. From your profile, click the Affiliations section. Select Request New Site Affiliation and search for the office by name or address. Your affiliation request will be sent to the Office Administrator for approval.



Introduction

Signing Up for the Provider Portal For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

How do I remove an office affiliation?

Navigate to your name in the upper right-hand corner of the Provider Portal. Select **Profile** from the drop-down list. From your profile, click the **Affiliations** section. Find the office that you wish to no longer be affiliated with and click **Remove Site Affiliation**. Confirm that you no longer wish to be affiliated with the office.

Office Administrator

What is an Office Administrator?

An Office Administrator is an individual selected by the office to grant access to and manage the VyndaLink[®] Provider Portal for employees in the office (and affiliated offices, if applicable).

Who can be an Office Administrator?

Physicians or office leaders may elect to enter themselves or designate another user at the site as the Office Administrator. Anyone at the site who assists patients in obtaining their medications would be appropriate. It would be helpful for this individual to be familiar with the office employees, onboarding of new employees, and the Provider Portal.

Who is my location's Office Administrator?

It is up to your location to determine who your Office Administrator will be. You may want to discuss this with your location's senior leader, or whoever has been the primary person/lead for your site's use of the current VyndaLink Provider Portal.

Managing Patient Cases



Is an Office Administrator required for every

Iocation where there are Provider Portal users? Every office must have an Office Administrator for their site of service, but an Office Administrator may serve in this role for multiple locations, if applicable. Without an Office Administrator, your location will experience a delay in registering additional users to the VyndaLink Provider Portal.

Can a site or office have multiple Office **Administrators?**

No, only one person can serve as the Office Administrator per site. Office Administrators may, however, designate any number of "Approvers" who can also approve new Provider Portal users.

What am I agreeing to do if I elect to serve as my **location's Office Administrator?**

As the Office Administrator, you will be responsible for managing user access to the VyndaLink Provider Portal for your location(s). In addition to managing their own patients, the Office Administrator will have the authority to approve or revoke Provider Portal privileges for other users in their office. All VyndaLink Provider Portal users must register to gain Provider Portal access. Once a potential user submits a registration request, the Office Administrator will receive an email indicating that an employee at their site has requested access to the VyndaLink Provider Portal. Using the link provided in the email, you will be directed to the VyndaLink Provider Portal to review the employee's information and approve or reject the registration request. Once the Office Administrator takes either action, the pending user will receive an email notification that their registration has been either approved or denied.



Introduction

Signing Up for the Provider Portal For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

How do I submit my request to serve as my **location's Office Administrator?**

If no Office Administrator is assigned during the registration process, the user will be prompted to select an Office Administrator and provide their contact information. Within 2 business days of your submission, you will receive a call from a Program Representative to verify your information and complete your designation as the Office Administrator.

What if the Office Administrator is unavailable for a period of time?

The Office Administrator can promote an existing user to an "Approver."

What is an Approver?

An Approver is a general user selected and approved by the Office Administrator to assist with approving and denying VyndaLink Provider Portal user registrations for the staff in their office.

How does selecting an Approver work?

These individuals must still complete a registration on the VyndaLink Provider Portal, but the Office Administrator will then promote them from a general user to an Approver. Office Administrators are the only individuals who can promote general users to Approvers. While there can be only one Office Administrator per site, there is no limit to the number of Approvers per site.

Managing Patient Cases



What am I agreeing to do if I elect to serve as my location's Office Administrator?

As the Office Administrator, you will be responsible for mana user access to the VyndaLink Provider Portal for your location(s). In addition to managing their own patients, the C Administrator will have the authority to approve or revoke Provider Portal privileges for other users in their office. All VyndaLink Provider Portal users must register to gain Provid Portal access. Once a potential user submits a registration request, the Office Administrator will receive an email indicat that an employee at their site has requested access to the VyndaLink Provider Portal. Using the link provided in the ema you will be directed to the VyndaLink Provider Portal to revie the employee's information and approve or reject the registration, the pending user will receive an email notification that their registration has been either approved or denied.

How do I submit my request to serve as my location's Office Administrator?

If no Office Administrator is assigned during the registration process, the user will be prompted to select an Office Administrator and provide their contact information. Within 2 business days of your submission, you will receive a call from a Program Representative to verify your information and complete your designation as the Office Administrator.



Introduction

Signing Up for the Provider Portal

Setting Up Your Office



	What if the Office Administrator is u for a period of time?
aging	The Office Administrator can promote an existi "Approver."
Office	What is an Approver?
der ting	An Approver is a general user selected and ap Office Administrator to assist with approving a VyndaLink Provider Portal user registrations for their office.
nail, ew ration	How does selecting an Approver we These individuals must still complete a registrat VyndaLink Provider Portal, but the Office Admir then promote them from a general user to an A Administrators are the only individuals who can general users to Approvers. While there can be Office Administrator per site, there is no limit to of Approvers per site.

Managing Patient Cases

eSignature Registration

navailable

ing user to an

proved by the and denying or the staff in

ork?

tion on the nistrator will Approver. Office n promote e only one

o the number



Inviting Another User

How do I invite another person to be a portal user?

Click the "Invite User" tab. Fill out the form with the information of the user whom you want to invite, then click the "Request Registration" button. The invitee will receive a Provider Portal Creation Request email from the portal.



Whom can I contact for technical assistance or to suggest enhancements to the portal?

For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)



Introduction

Signing Up for the Provider Portal



What is the Case Status Report on the VyndaLink **Provider Portal dashboard?**

The Case Status Report is a dynamic, clickable dashboard to view cases that require actions. Each bar shows the quantity of the different types of cases. Click a bar to access the list of related cases.

How do I receive Missing Information notifications?

Cases that contain missing information will be visible in the My Cases view. All your cases will contain a colored label. The "Action Needed" label is red and signifies that the case requires you to complete a step before moving further in the process. The Cases views can be filtered by "Action Needed" only.

If you would like to receive email notifications for your cases with missing information, navigate to your name in the upper right-hand corner of the Provider Portal. Select **Profile** from the drop-down list. From your profile, click the **Email Notifications** section. Select the "Action Needed" boxes (individual or daily) for the cases you wish to be notified about.

Managing Patient Cases

VyndaLink Provider Portal Troubleshooting

- Portal user should follow the troubleshooting tips below
- Hotline at 855-764-7357 (Monday-Friday 9AM-5PM ET); this number is ONLY for technical support.
- Portal user should be in front of their computer and go to: <u>www.VyndaLinkPortal.com</u>
- Portal user must be able to identify the email address that was used for their portal registration



Troubleshooting Tips:

Password Issues

Examples: User not receiving password reset emails or me "Email already in use" when attempting to reset password

- Password for the VyndaLink Portal expires every 120 day User will receive an email notifying them the password wi in next 14 days. User MUST take action and reset passwo BEFORE 14th day. User will be locked out of portal if pas reset directions are not followed.
- User should click on the link in the email to reset the particular by first answering the security questions
- Password Resets
- Click "Forgot Password" option on the landing page of provider portal and enter user email address associated VyndaLink Provider Portal
- Within ~2 hours, user will receive an email with a link to their password. Link expires in 24 hours.



Introduction

Signing Up for the Provider Portal

Setting Up Your Office



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET)

• If the portal technical issue is unresolved, the portal user can contact their Pfizer Field Access Specialist or call the VyndaLink Provider Portal

- Portal user should be able to identify their portal Site Administrator and know if this person has granted them access to the portal

	 If User is not receiving password reset emails an completed the registration process, user should
essage	 Ensure they are entering email address associ VyndaLink Provider Portal
/s. fill expire ford ssword	 User has clicked "Password Reset" and has c User has checked their SPAM/JUNK folder for User has confirmed organization/employer do Provider Portal emails or portal usage
assword	Portal user is not seeing their patier
the d with the	 Portal user must first confirm the Site and the spare affiliated to their portal user profile. If they are affiliated to the user, then the user will not see the for that provider.
reset	 User must log into Portal to confirm the Site and are both affiliated to their user profile and appro Site Administrator

Managing Patient Cases

eSignature Registration

nd user has fully

iated with the

checked their email r the email es not block

nts/cases

pecific provider re not both he patients/cases

d this Provider oved by the

User Password Information



For portal technical support, call the VyndaLink Provider Portal Hotline: 855-764-7357 (Monday-Friday 9ам-5рм ET).

VYNDAMAX[®] and VyndaLink[®] are registered trademarks of Pfizer Inc. PP-VDM-USA-1188 © 2023 Pfizer Inc. All rights reserved. June 2023



Introduction

Signing Up for the Provider Portal

Setting Up Your Office



Enrolling Patients

Managing Patient Cases eSignature Registration User Password Information

