VyndaLink
Connecting Access, Reimbursement, and Education

VyndaLink® Enrollment Form

Fields marked with * are required.

If you are commercially insured and in need of co-pay assistance only, please visit www.VyndaLink.com/patient/financial support. You are not required to complete this form unless you are in need of additional patient support.*

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

Program Overview

VyndaLink is a personalized patient support program that offers resources for patients prescribed VYNDAMAX® (tafamidis).† We provide reimbursement support, as well as help identifying financial assistance options for eligible uninsured and government-insured patients who are unable to afford their co-payment.

By enrolling in **VyndaLink**, patients may receive various support and information designed to help patients access their prescribed Pfizer medication, which may include, but is not limited to, the following (collectively, "Patient Support Activities"):

- Providing benefits investigations and reimbursement support, including:
  - Educating patients about their insurance coverage for their prescribed medication
  - Assisting with identification of the insurer's prior authorization and/or appeal requirements, if applicable
- Provision of financial assistance resources and information, if the patient is uninsured or government insured and unable to afford their co-payment, and determining whether the patient may be eligible based on available information

Contact Us

- If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET
- Please use one of the options below to complete and submit the **VyndaLink** Enrollment Form:
  - Fax to: 1-888-878-8474
  - Mail to: **VyndaLink**, PO Box 221296, Charlotte, NC 28222
  - Submit the fully completed form or required documents at www.patientsupportnow.org using patient support code 8888788474
  - Patients may complete electronically online via eSign through www.VyndaLink.com
  - Providers may complete electronically online at www.VyndaLinkPortal.com

Please note, you must complete all required fields on this enrollment form. If there is any information missing on this form, **VyndaLink** may contact you to obtain the required information as they cannot complete your request without all required information.

ENROLLMENT CHECKLIST FOR **PATIENTS**	ENROLLMENT CHECKLIST FOR **HEALTHCARE PROVIDERS (HCPs)**
☐ The patient or their caregiver (if patient is unable to **complete** the form) should complete the enrollment form online at www.VyndaLink.com or all required boxes marked with an asterisk in the patient section of the paper enrollment form (see pages 2-5)	☐ Complete all required boxes in the Provider sections of this form on pages 6-9, inclusive of signature, date and Consents/Attestations
☐ If you are **uninsured or government insured** but experiencing a financial hardship affording your medication, **complete** all information on page 4, and attach proof of income if you are not consenting to electronic income verification. Commercially insured patients are not eligible for the Pfizer Patient Assistance Program*	☐ Provide primary ICD-10 diagnosis codes and any secondary diagnosis codes, if applicable
☐ Read all required Patient Authorizations/Attestations and Disclosures on pages 3 and 5 (and also page 4 if applying for the Pfizer Patient Assistance Program), and **sign/date** in the signature areas. Check the appropriate boxes on page 3 if you would like to sign up for text message alerts from VyndaLink	☐ If your patient is requesting financial assistance through the Pfizer Patient Assistance Program (PAP) for the first time, you are required to provide all required Prior Authorization and Specialty Pharmacy information in Section 6A-1
☐ The enrollment form may be submitted **online**; see the instructions above. If not submitting the form online, **return** all pages of the patient section of the paper Enrollment Form to VyndaLink via mail or fax, or give to your Healthcare Provider to submit for you. Ask your doctor to **complete, sign, and submit** the Healthcare Provider pages of the Enrollment Form	☐ If your patient is currently enrolled in the Pfizer PAP and requesting re-enrollment, work with your patient to complete all required sections on page 4. You, the healthcare provider, must provide all the required information in Section 6A. **IMPORTANT:** if your re-enrolling PAP patient's insurance has changed, you will need to submit their prescription to the pharmacy to verify the patient's co-pay before **VyndaLink** can assess for PAP re-enrollment. If your patient cannot afford their medication, submit the required fields in Section 6A-1 of this enrollment form.
☐ Make a photocopy of your completed Enrollment Form before you submit the original to **VyndaLink**	☐ Instruct patient to complete the patient section of the enrollment form, and **sign/date** all patient consents

*Effective January 1, 2023, commercially insured patients are not eligible to receive assistance through the Pfizer Patient Assistance Program (PAP). However, if you are a re-enrolling patient who was approved for PAP in 2022 with commercial insurance and are commercially insured again in 2023, you may be considered for re-enrollment.

† The same **VyndaLink** support offerings available to patients prescribed VYNDAMAX may also be available to patients prescribed VYNDAQEL® (tafamidis meglumine).

See next page to continue completing the Patient section of the Enrollment Form.

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VyndaLink® Enrollment Form: Patient

Fields marked with * are required.

Complete the required information on pages 2, 3, 4, and 5 and fax to 1-888-878-8474, mail to **VyndaLink**, PO Box 221296, Charlotte, NC 28222, or submit online to www.VyndaLink.com. If applying for the Pfizer Patient Assistance Program, also complete and submit page 4. If you have questions, please call **VyndaLink** at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

For Patients

1. Patient Information

Patient First Name*_____ Middle Initial____ Last Name*_____

Gender* ☐ Male ☐ Female ☐ Not Disclosed Date of Birth (mm/dd/yyyy)*_____ Email_____

Address Line 1*_____

Address Line 2 _____

City*_____ State*_____ ZIP Code*_____

Primary Phone*_____ ☐H ☐W ☐M Alternate Phone_____ ☐H ☐W ☐M OK to Leave a Message ☐ Language Preference_____

Patient Caregiver Name_____ Caregiver 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)

☐ Medicare, Medicaid or other government insurance plans ☐ Commercial ☐ Uninsured

Primary Insurance Name*_____

Primary Insurance Phone Number*_____ Policy/Group #*_____

Policyholder same as patient?* ☐Yes ☐No Policyholder Name (First, MI, Last) (if other than patient)*_____

Policyholder Date of Birth (mm/dd/yyyy)*_____ Policyholder Relationship to Patient*_____

Secondary Insurance Name_____

Secondary Insurance Phone Number_____ Policy/Group #_____

Policyholder same as patient? ☐Yes ☐No Policyholder Name (First, MI, Last) (if other than patient)*_____

Policyholder Date of Birth (mm/dd/yyyy)_____ Policyholder Relationship to Patient_____

Prescription (Rx) Insurance Name* (if applicable)_____

Policy #*_____ Group #*_____ Rx BIN #*_____

If the patient is insured through a Medicare Prescription Drug Plan, please include the full plan address. (This address is required if you have a Medicare Part D plan and are eligible for the Pfizer Patient Assistance Program or Interim Care.)

Medicare Part D Address:_____

If you have a Medicare Part D plan and are eligible for the Pfizer Patient Assistance Program and/or the Interim Care program, **VyndaLink** will notify your Part D plan of your enrollment in the program.

See next page to continue completing the Patient section of the Enrollment Form.

VyndaLink
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VyndaLink® Enrollment Form: Patient

Fields marked with * are required.

Patient Authorizations, Attestations, and Disclosures

Complete the required information on pages 2, 3, 4, and 5 and fax to 1-888-878-8474, mail to **VyndaLink**, PO Box 221296, Charlotte, NC 28222, or submit online to www.VyndaLink.com. If applying for the Pfizer Patient Assistance Program, also complete and submit page 4. If you have questions, please call **VyndaLink** at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

Patient Name (First/MI/Last)* _____ **Patient DOB (mm/dd/yyyy)*** _____

3A. Patient Consent to Receive Communications (Required if you want to receive phone calls and other communication)

By signing this form, I agree to receive communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, information and other Patient Support Activities (such as co-pay support or free drug programs) and for other non-marketing purposes. I agree to be contacted by Pfizer, **VyndaLink**, or parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number(s) provided. If I have a caregiver, he or she also agrees to receive such communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf for the purposes described above, and hereby gives his or her permission for Pfizer, **VyndaLink**, and/or parties acting on their behalf to contact him or her for such purposes at the phone number(s) provided. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting **VyndaLink** at 1-888-222-8475.

Consent to Receive Emails (Optional)

☐ By checking this box and providing my email address, I consent to receive program information, enrollment status, shipping updates, and refill reminders from **VyndaLink** via email. Email will be one-way communication identified as **VyndaLink** from a "Do Not Reply" email box. I can opt out of these emails anytime by contacting **VyndaLink** at 1-888-222-8475.

Email address: _____

Consent to Receive Text Messages (Optional)

☐ By checking this box and providing my mobile number, I consent to receive enrollment status, shipping updates, and refill reminders from **VyndaLink** via text message. I will receive a welcome text asking me to reply YES to opt in. See terms and conditions for mobile messaging at rebrand.ly/dxzxpa and Pfizer's Privacy Policy at Pfizer.com/privacy. Up to 10 messages/month. Message and data rates may apply. Text HELP to 98557 for information and STOP to opt out.

Please enter the number you would like to enroll for texting (_____) _____ - _____ .

PRINT HERE

Print Name of Patient*

SIGN HERE

Patient Signature* Date*

Print Name of Caregiver (Required if you have a caregiver who will be communicating with VyndaLink)

Caregiver Signature Date

3B. Pfizer Patient Access Coordinator Opt-in (Optional)

When you enroll in **VyndaLink**, you have the option to be contacted by a Pfizer Patient Access Coordinator (PAC) who can help you understand your insurance benefits and navigate the process to access your prescribed medication. Pfizer PACs are field-based employees of Pfizer Rare Disease and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. Pfizer PACs are very familiar with access and reimbursement requirements for VYNDAMAX® (tafamidis),† and the Pfizer PAC assigned to you will coordinate with **VyndaLink** and you on your journey to starting therapy (although you will still need to contact **VyndaLink** directly if you are seeking financial assistance). Working with a Pfizer PAC is optional. Even if you choose not to opt-in for this support, you may still access all Patient Support Activities you are eligible for by working with a case manager at **VyndaLink**.

☐ By checking this box, I request Pfizer PAC support and agree to receive telephonic communications from the Pfizer PAC assigned to my case as described above. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services. I understand that I can opt out of support from and communications with the Pfizer PAC at any time by contacting **VyndaLink** at 1-888-222-8475.

†The same **VyndaLink** support offerings available to patients prescribed VYNDAMAX may also be available to patients prescribed VYNDAQEL® (tafamidis meglumine).

See next page to continue completing the Patient section of the Enrollment Form.

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Fields marked with * are required.

4A. Pfizer Patient Assistance Program (PAP) Enrollment (Required if applying for Financial Assistance)

Please identify your PAP status AND answer the question below*:

☐ Initial PAP Applicant (uninsured or government-insured patient): ☐ Re-enrolling PAP patient with an insurance change:
My provider or pharmacy has reviewed my insurer-required co-payment with me and I certify that I am unable to afford this medicine.
☐Yes ☐No

OR

☐ Re-enrolling PAP patient with no insurance changes:
I certify that my benefits have not changed and I am unable to afford my insurer-required co-payment. ☐Yes ☐No

Patient Name (First/MI/Last)* _____ **Patient DOB (mm/dd/yyyy)*** _____

The Pfizer Patient Assistance Program provides eligible uninsured and government-insured patients with access to their prescribed Pfizer medication for no cost. If you are not commercially insured and requesting financial assistance, complete all required sections on this page to be evaluated for any available financial assistance options.† Commercially insured patients are not eligible for the Pfizer Patient Assistance Program. For PAP eligible patients, you will be required to reapply annually.

Prior to being evaluated to qualify for the Pfizer Patient Assistance Program, a search for alternate funding resources may be completed, where applicable. If alternate funding resources are found, patients will be required to apply.

4B. Patient Consent for Pfizer Patient Assistance Programs (Required–Only if applying for the Pfizer Patient Assistance Program)

The information you provide will be used by Pfizer, VyndaLink, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve Pfizer's assistance programs, to communicate with you about your experience with Pfizer's assistance programs, to help you understand your insurance coverage and help you access certain Pfizer medications through your insurance, 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 have been prescribed the requested medicine for an FDA-approved diagnosis and cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge.

I understand that: Completing this enrollment form does not guarantee that I will qualify for the Pfizer Patient Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medications supplied by the Pfizer Patient Assistance Program shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Pfizer Patient Assistance Program, Pfizer will notify my Part D Plan of my enrollment in the Pfizer Patient Assistance Program. If I am commercially insured, I cannot receive assistance through the Pfizer Patient Assistance Program.

I certify and attest that if I receive medication provided by Pfizer through the Pfizer Patient Assistance Program: I will promptly contact the Pfizer Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medication or any cost from it counted in my Medicare Part D true out-of-pocket costs (TrOOP) for prescription drugs. I will not submit claims, seek reimbursement or credit for the medication from my prescription insurance provider or payor, including Medicare Part D plans.

By signing below, I certify and acknowledge that I have read, understand, and agree to the above terms.

SIGN HERE

Patient Signature* (Patient or personal representative of patient)	Date*

4C. Patient Financial Information (Required–Only if applying for the Pfizer Patient Assistance Program)

This information is required to search for alternate funding assistance and verify eligibility for the Pfizer Patient Assistance Program†, if available, and the patient is uninsured or insured but is unable to afford their medication.

Total Number of People Within Household (including applicant)* _____ Total Annual Household Income* $ _____

If you do not want your income verified electronically, or if the electronic verification process cannot successfully determine your household income, you will need to submit documentation to support the financial information you've listed. Acceptable forms of income documentation for all members of the household include the following:

☐ Most recent federal tax return (Page 1 of IRS 1040 form) ☐ W-2 form ☐ Three (3) most recent pay stubs ☐ Social Security Award Letter ☐ Other

4D. Patient Authorization for Electronic Income Verification (Optional–Only if applying for the Pfizer Patient Assistance Program)

I understand that I am entitled to a copy of this Authorization upon request. This Authorization shall be valid for two (2) years from the date of the signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to **VyndaLink** at PO Box 221296, Charlotte, NC 28222, but that this cancellation will not apply to any information already used or disclosed through this Authorization. Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements and agree to the outlined terms.

I, the applicant named above, understand that I am providing "written instructions" to Pfizer, **VyndaLink**, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf under the Fair Credit Reporting Act authorizing **VyndaLink** to obtain information from my credit profile or other information from Experian™ Income View℠. I authorize Pfizer to obtain such information solely for the purpose of determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Pfizer Patent Assistance Program financial screening process.

SIGN HERE

Patient Signature* (Patient or personal representative of patient)	If personal representative, indicate relationship	Date*

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation. Free medications from Pfizer are provided through the Pfizer Patient Assistance Foundation. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions. If you have a Medicare Part D plan and are eligible for the Pfizer Patient Assistance Program, **VyndaLink** will notify your Part D plan of your enrollment in the Pfizer Patient Assistance Program.

See next page to continue completing the Patient section of the Enrollment Form.

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5. Patient Authorization to Share Health Information*

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

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of my insurer's prior authorization requirements
  - Assisting with identification of my insurer's requirements for appealing a denied claim
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Sending me a Welcome letter
- Communicating with my Healthcare Providers about a Pfizer medication and Patient Support Activities
- Providing me with financial assistance resources and information if I'm eligible
- Providing me with disease management and other educational materials, and may include sending me surveys about my experience with Pfizer's Patient Support Activities

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services.

I understand that I do not have to sign this form and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, **VyndaLink** may not be able to provide me with assistance.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Pfizer agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me. I understand that this form will remain in effect for 4 years from the date of my signature unless I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact **VyndaLink** at PO Box 221296, Charlotte, NC 28222, Monday-Friday, 8 AM-8 PM ET. This withdrawal will not affect the use or sharing of my health information that took place before I withdrew my approval. I understand I may receive a copy of this form.

I also give my permission to receive communications from Pfizer, **VyndaLink**, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. If I have a caregiver, he or she also agrees to receive such communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf for the purposes described above at the phone number(s) provided, and hereby gives his or her permission for Pfizer, **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 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

PRINT HERE **Print Name of Patient***	SIGN HERE **Signature of Patient***	**Date***
PRINT HERE **Print Name of Caregiver/Authorized Patient Representative**	SIGN HERE **Signature of Caregiver/Authorized Patient Representative**	**Relationship to Patient**

See next page to continue completing the Healthcare Provider section of the Enrollment Form.

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VyndaLink® Enrollment Form: Provider

Fields marked with * are required.

(This section to be completed by a Healthcare Provider or Physician/Licensed Prescriber)

Complete any required information on pages 6, 7, 8, and 9 for HCP enrollment and prescription information, and pages 2-5 on behalf of the patient, as needed. Fax to 1-888-878-8474, mail to **VyndaLink**, PO Box 221296, Charlotte, NC 28222, or submit online to www.VyndaLinkPortal.com. If you have questions, please call **VyndaLink** at 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

Patient Name (First/MI/Last)* _____ **Patient DOB (mm/dd/yyyy)*** _____

6A. Healthcare Provider Enrollment Type

Services Requested* (Please select all services desired for your patient.)

☐ Benefits Verification, Prior Authorization (PA)/Appeals Assistance (if applicable)

☐ Enrollment in VYNDAMAX® (tafamidis)† Co-pay Savings Program only

☐ New enrollment in the Pfizer Patient Assistance Program (PAP)‡§
- ☐ Uninsured Patient§
- ☐ Government-Insured Patient§
  (Complete required fields below in 6A-1.)

☐ Re-enrollment in the Pfizer Patient Assistance Program (PAP)‡
- ☐ Re-enrolling with no insurance change
- ☐ Re-enrolling with an insurance change§
  (Complete required fields below in 6A-1.)

6A-1. Healthcare Provider PAP Enrollment Information

(The information below is required ONLY for PAP newly enrolling government-insured patients OR PAP re-enrolling patients with an insurance change.)

Does your patient understand their required co-pay and have they directly communicated their inability to afford this co-pay to you?* ☐ Yes ☐ No

Is your patient's Pfizer medication covered by either medical or prescription insurance?* ☐ Yes ☐ No ☐ I don't know

What is the co-pay amount as verified by the Specialty Pharmacy Provider (SPP)?* _____ ☐ I don't know

SPP Name* _____ SPP Phone Number* _____

Prior Authorization/Predetermination begin date (mm/dd/yyyy)* _____ End date (mm/dd/yyyy)* _____

Prior Authorization Number* _____ ☐ No PA required by Payer

See sections 4A-4D for PAP patient information, requirements and consents. Please review with your patient and instruct them to complete 4A-4D if applying for PAP.

6B. Healthcare Provider Identification

HCP Name (First/MI/Last)* _____ HCP Specialty _____

Practice/Institution Name* _____ Address* _____

City* _____ State* _____ Zip Code _____

NPI #* _____ Group Tax ID # _____ State License # _____ DEA # _____

Fax* _____ Email _____

Office Contact Name* _____ Office Contact Phone* _____

If Third Party Supporting Patient Enrollment for HCP: Third-Party Business Name* _____

Third-Party Contact Name* _____ Third-Party Contact Phone* _____

†The same **VyndaLink** support offerings available to patients prescribed VYNDAMAX may also be available to patients prescribed VYNDAQEL® (tafamidis meglumine). Certain restrictions apply.

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

§For all new PAP enrollments or PAP re-enrolling patients with insurance change, the HCP must send the VYNDAMAX prescription to the Specialty Pharmacy Provider (SPP) for a benefits verification/test claim to obtain patient liability for co-pay. The patient must be notified of their required co-pay and have directly expressed an inability to afford prior to requesting financial assistance through **VyndaLink**.

See next page to continue completing the Healthcare Provider section of the Enrollment Form.

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Patient Name (First/MI/Last)* _____ **Patient DOB (mm/dd/yyyy)*** _____

7A. Healthcare Provider Certification

I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I will receive and secure my patient's medication at my office until it is dispensed to my patient, when applicable. If applicable, I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers. Any medications supplied by Pfizer as a result of this enrollment form are for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. The medication will be provided only to this eligible and enrolled patient at no charge of any kind. The information provided on this enrollment form is subject to random audits and verification. Pfizer may change or cancel this program at any time; Pfizer also reserves the right to terminate my patient's enrollment at any time.

7B. Healthcare Provider HIPAA and Consent to Receive Communications

By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pfizer and its employees or agents for purposes relating to Pfizer's patient support programs, including assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and other Patient Support Activities, such as co-pay support or free drug programs, for which the patient may be eligible, and other patient support for the prescribed Pfizer medication(s).

I certify that I have obtained consent from the patient and/or the patient's caregiver to be contacted by Pfizer, **VyndaLink**, and parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Pfizer, **VyndaLink**, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

SIGN HERE _____ **HCP Signature***	_____ **Date***
_____ **HCP Email Address** (If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this)	

See next page to continue completing the Healthcare Provider section of the Enrollment Form.

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Patient Name (First/MI/Last)* _____ **Patient DOB (mm/dd/yyyy)*** _____

8A. Prescription Information*

(Please complete all boxes and include prescription when requesting a Benefits Verification or assistance through the Pfizer Patient Assistance Program [PAP], Interim Care, or transfer to a Specialty Pharmacy.)

Primary ICD-10 Diagnosis Code* _____ Secondary ICD-10 Diagnosis Code _____

Please note: The patient's diagnosis must be on-label to be evaluated for PAP.

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

Patient's Concurrent Medications: _____

Other Known Conditions: _____

8B. Prescription Information

Please check the medication prescribed and indicate strength & quantity. Please provide complete directions and dosing information below.

Prescription

☐ VYNDAMAX 61 mg: One 61 mg tafamidis capsule orally once daily, Quantity #30 capsules (30 days)

Refills #_____

Interim Care Program

(for eligible patients, new to therapy, insured by a commercial or federal insurance program)

If eligible, free VYNDAMAX may be provided at no cost if a delay occurs in the coverage determination process. Limits, terms, and conditions apply.† Patient may be additionally covered up to 60 days if eligible for refill.

Prescription

☐ VYNDAMAX 61 mg: One 61 mg tafamidis capsule orally once daily; Quantity #30 capsules (30 days)

Refills #_____

Pfizer Patient Assistance Program

(for eligible uninsured and government-insured patients only)

Patients must reapply annually. Limits, terms, and conditions apply.‡

Prescription

☐ VYNDAMAX 61 mg: One 61 mg tafamidis capsule orally once daily; Quantity #30 capsules (30 days)

Refills #_____

8C. Prescription Signature

(Required if requesting assistance through Pfizer Patient Assistance Program, Interim Care, or transfer to a Specialty Pharmacy. No stamps allowed.)

Note: New York practitioners are required to electronically prescribe. E-prescriptions to AmeriPharm (NPI number-1073692745; NCPDP number-4351968), or MedVantx under retail pharmacies (NPI number-1235371535; NCPDP number-4354180) will be sent to the same place.

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

_____ **Prescriber's Signature*** Dispense As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	_____ **Date***
_____ **Prescriber's Signature*** May Substitute / Product Selection Permitted / Substitution / Permissible	_____ **Date***
_____ **CA, MA, NC, & PR** Interchange is mandated unless Prescriber writes the words "**No Substitution**" / ATTN: New York and Iowa providers, please submit electronic prescription	

HCP Email Address (Provide if signing electronically) _____

† See terms and conditions on page 9.

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

See next page to continue completing the Healthcare Provider section of the Enrollment Form.

VyndaLink
Connecting Access, Reimbursement, and Education

VyndaLink® Enrollment Form: Provider

Fields marked with * are required.

(This section to be completed by a Healthcare Provider or Physician/Licensed Prescriber)

VyndaLink Interim Care†

The Interim Care program may provide new, eligible patients with up to 60 days of free VYNDAMAX® (tafamidis) shipping directly to patients (or HCPs for physician-administered drugs) who have provided a completed Interim Care program VYNDAMAX prescription (page 8) and who have experienced a delay in coverage determination of 5 or more business days from the submission of a prior authorization or appeal directly to the patient's insurer.

For patients who have a Medicare Part D plan and are eligible for the VYNDAMAX Interim Care program, **VyndaLink** will notify the Part D plan of the patient's enrollment in the Interim Care program.

Note: The Interim Care prescription section must be filled out on page 8, section 8B.

For Healthcare Providers (Fields marked with * are required.)

Patient Name (First/MI/Last)* _____ **Patient DOB (mm/dd/yyyy)*** _____

9. Prescriber Acknowledgment of Interim Care Program Terms and Conditions* (Required if requesting Interim Care)

Date authorization/appeal request was made to the patient's insurer _____

Interim Care Program Terms and Conditions

- Interim Care is not health insurance and is only available for eligible patients who are insured through a commercial or federal insurance program.
- Offer is only available for patients new to therapy (excluding any participation in a clinical trial) who have a valid prescription and an on-label diagnosis for VYNDAMAX.
- Interim Care is only for new patients whose authorization and/or appeal has been requested/submitted to the patient's insurer and who have experienced a delay in coverage determination of at least 5 business days from the submission of a prior authorization or appeal directly to the patient's insurer.
- Neither the patient, nor the pharmacy or anyone else acting on the patient's behalf, may submit any claim for reimbursement for product dispensed pursuant to this Interim Care program to any third-party payer, including Medicare, Medicaid, or any other federal or state healthcare program. Out-of-pocket expenses incurred when using this program cannot be applied toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).
- This program cannot be combined with any other savings, free trial or similar offer for the specified prescription.
- The product provided in the Interim Care program is free of charge and the patient should not be billed by anyone for this product.
- If the patient is enrolled in a Medicare Part D plan, they must provide the address of their plan in order to be eligible for the Interim Care program.
- Available in 30-day supply. Refills are subject to limitations.
  - To be eligible for an additional 30-day refill, the patient must be actively pursuing coverage through their insurance awaiting a prior authorization/appeal decision. Interim Care for VYNDAMAX may not exceed 60 days for any patient.
- Interim Care offer does not require, nor will be made contingent on, purchase requirements of any kind.
- Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification.
- Interim Care can only be dispensed by the exclusive pharmacy and only after benefits investigation has been completed and a delay has occurred in the prior authorization or appeals process.
- Offer good only in the US and Puerto Rico.
- Prescription must be provided by a healthcare provider licensed in the US or Puerto Rico.
- Additional eligibility criteria may apply. Contact **VyndaLink** for details.

I confirm that my patient is new to VYNDAMAX therapy and currently has a pending authorization/appeal with their insurer if I have provided the date the authorization and/or appeal request was made above.

I attest to the accuracy of the information provided on this form, including the date the authorization/appeal request was made to the patient's insurer to request coverage for VYNDAMAX if already completed.

I consent to the Terms and Conditions of the Interim Care program and attest that I will not submit any claim for reimbursement for product dispensed pursuant to this Interim Care program to any third-party payer, including Medicare, Medicaid, or any other federal or state healthcare program. Out-of-pocket expenses incurred when using this program cannot be applied toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).

SIGN HERE _____ **Prescriber's Signature***	_____ **Date***

†The same **VyndaLink** support offerings available to patients prescribed VYNDAMAX may also be available to patients prescribed VYNDAQEL® (tafamidis meglumine).

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