VyndaLink Enrollment Form

VyndaLink™
Connecting Access, Reimbursement, and Education

Please complete this form and either fax to 1-888-878-8474, complete online at **www.VyndaLinkPortal.com**, or mail to **VyndaLink** at PO Box 221296, Charlotte, NC 28222.

Patients may be able to submit authorization portions of this form online through eSign by visiting **VyndaLink.com**.

If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

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

By enrolling in the **VyndaLink** program, patients will receive various forms of support and information to help access VYNDAMAX® (tafamidis), which may include the following, depending on the program (collectively, "patient support activities"):

- Providing benefits investigations/verification and reimbursement support, including assistance with identifying patient insurer requirements for prior authorization and appealing a denied claim
- Determining patient eligibility for and access to co-pay support or free drug programs
- Communicating with healthcare providers about VYNDAMAX patient support activities
- Providing patients with financial assistance resources and information, if eligible
- Providing patients with disease management and other educational materials, as well as information about Pfizer's products, services, and programs (which may include surveys about patient experience with Pfizer products, services, and programs)

ENROLLMENT CHECKLIST FOR PATIENTS

- ☐ Complete all required sections marked with an asterisk * on pages 2-5
- ☐ If you are seeking financial assistance, complete all financial information in section 3, sign section 4, and authorize electronic income verification in section 4A (optional, but may reduce application review time). If you do not want your income verified electronically, you will need to attach documentation of your total annual income, such as federal tax return, W-2, or other
  - – If submitting a tax return, only include page 1 of the IRS 1040 Form
- ☐ Provide copies of your insurance and prescription card(s)—front and back sides. If you are enrolled in Medicare, provide a copy of your medical and pharmacy cards
- ☐ Be sure to sign and date the Consent to Receive Communications (section 5) and Patient Authorization to Share Health Information (section 7). If interested in the Pfizer Patient Access Coordinator Opt-in, see section 6A. For **VyndaLink** Patient Support Navigator Opt-in, see section 6B.
- ☐ If you have a caregiver who will be communicating with **VyndaLink**, they should complete and sign their portion of sections 5 and 7
- ☐ Make a photocopy of your enrollment form, as it will not be returned to you
- ☐ Ask your doctor to complete, sign, and submit the healthcare provider portion of the form (sections 8-12)

ENROLLMENT CHECKLIST FOR HEALTHCARE PROVIDERS

- ☐ Complete all required sections marked with an asterisk * on pages 6-8
  - – Provide Prescription Information, including Directions/Dosing Instructions in section 9
  - – Review and sign Healthcare Provider Consent and Signature in section 10
  - – Review and sign Healthcare Provider HIPAA and TCPA Attestation in section 11
- ☐ Complete the Interim Care program prescription and consents on pages 6-8 if your patient may need assistance through the Interim Care program
- ☐ Instruct patient to review and sign the enrollment form and Patient Authorization to Share Personal Health Information form
  - – Retain the original signed form with the patient's records and provide a copy to the patient
  - – Medical records are not required; do not include in the fax
- ☐ Ensure all required fields are complete
- ☐ Fax the completed enrollment form, including the signed Patient Authorization to Share Personal Health Information form, to 1-888-878-8474

If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

VyndaLink ENROLLMENT FORM: PATIENT

Complete this form and submit with copies of both sides of the patient's insurance cards. You can fax it to 1-888-878-8474 or mail it to **VyndaLink** at PO Box 221296, Charlotte, NC 28222. If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

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For Patients Fields marked with * are required.

1. Patient Information

Name (First, MI, Last)*		Gender* ☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)*	Email	
Street Address*		
City*	State*	ZIP Code*
Primary Phone* Cell Phone	☐ OK to leave message	Language Preference

2. Insurance Information (Please include a copy of both sides of your insurance and prescription card[s].)

☐ Check here if patient does **not** have insurance ☐ Check here if patient has secondary insurance

Primary Insurance Name*		
Primary Insurance Phone Number*	Policy/Group #*	
Primary Policyholder Name (First, MI, Last) (if other than patient)*		
Primary Policyholder Date of Birth (mm/dd/yyyy)*	Primary Policyholder Relationship to Patient	

Is VYNDAMAX® (tafamidis) covered? ☐ Yes ☐ No ☐ I don't know If yes, what is the co-pay amount? ☐ I don't know

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‡:		

3. Patient Financial Information*

This information is required to search for alternate funding support and verify eligibility for the Pfizer Patient Assistance Program† as appropriate. If you are requesting financial assistance resources, you must read and sign section 4 on the next page. If you do not complete this section, **VyndaLink** cannot evaluate financial assistance resources for which you may be eligible.

Total number of people within household (including applicant)	Total annual household income $
If you do not want your income verified electronically, you will need to submit documentation to support the financial information you've listed. Attached is: ☐ Most recent federal tax return ☐ W-2 form ☐ Other	

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

‡If you have a Medicare Part D plan and are eligible for the **VyndaLink** Interim Care program, **VyndaLink** will notify your Part D plan of your enrollment in the Interim Care program.

See next page to continue completing the patient section of the enrollment form.

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For Patients Fields marked with * are required.

4. Patient Consent for Pfizer Patient Assistance Programs* (Required if you entered financial information in section 2.)

The information you provide will be used by Pfizer Inc. ("Pfizer"), the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

Patient Declaration—By signing below, I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. **I understand that:** Completing this enrollment form does not guarantee that I will qualify for the Pfizer Patient Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by the Pfizer Patient Assistance Program shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Pfizer Patient Assistance Program, Pfizer will notify my Part D Plan of my enrollment in the Pfizer Patient Assistance Program.

I certify and attest that if I receive medicine(s) provided by Pfizer through the Pfizer Patient Assistance Program: I will promptly contact the Pfizer Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D true out-of-pocket costs (TrOOP) for prescription drugs. I will not submit claims, seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans. I will notify my insurance provider of the receipt of any medicines through the Pfizer Patient Assistance Program. I have a signed copy of a current and completed HIPAA Authorization Form on record with my Prescriber so that my Prescriber may share health information about me with the Pfizer Patient Assistance Program, Pfizer, and the Pfizer Patient Assistance Foundation Inc.

Patient Signature (Patient or Personal Representative of Patient)*	Date*
Sign here	

4A. Patient Authorization for Electronic Income Verification (Optional, but may reduce application review time)

I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Reporting Act authorizing Pfizer Inc. to obtain information from my credit profile or other information from Experian Income View. I authorize Pfizer Inc. to obtain such information solely for the purpose of determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I 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 PO Box 220158, Charlotte, NC 28222, but this cancellation will not apply to any information already in use 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.

Patient Signature (Patient or Personal Representative of Patient)	Date
Sign here	

See next page to continue completing the patient section of the enrollment form.

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For Patients Fields marked with * are required.

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

By signing this form, I agree to communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf 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. 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. 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.

Print Name of Patient*

Print here

Patient Signature*	Date*
Sign here	

For Patient Caregiver* (Required if you have a caregiver who will be communicating with **VyndaLink**)

Print Name of Caregiver*	Caregiver Phone
Print here	
Caregiver Signature*	Date*
Sign here	

6A. 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 programs 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.

6B. **VyndaLink** Patient Support Navigator Opt-in (Optional)

Personalized patient support is offered through **VyndaLink** via Patient Support Navigators. You can speak with **VyndaLink** Patient Support Navigators for resources that may help with your daily life. Your Patient Support Navigators may provide information about your condition, VYNDAMAX® (tafamidis) medicine, healthy living tips, financial assistance, and Medicare Open Enrollment. Patient Support Navigators can also connect you to independent organizations that provide services such as transportation for your treatment-related appointments. These offerings may vary based on your prescribed medicine. To opt-in to this program, please check the box below.

☐ By checking this box, I request Patient Support Navigators' support and agree to communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf, including but not limited to autodialed and prerecorded calls to the phone number provided. These communications may include, for example, offers, resources, and other support such as those described above. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services. I understand I can opt out of these communications at any time by contacting **VyndaLink** at 1-888-222-8475.

See next page to continue completing the patient section of the enrollment form.

VyndaLink ENROLLMENT FORM: PATIENT

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Fields marked with * are required.

7. Patient Authorization to Share Health Information*

By signing this form, I give my 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 and partners (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 your insurer's prior authorization requirements
  - Assisting with identification of your 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 device and starter kit (where appropriate)
- Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities
- Providing me with financial assistance resources and information if I'm eligible
- Providing me with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve our 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, the **VyndaLink** program 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 or from redisclosure. 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 four (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 or 1-888-222-8475. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw 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, and he or she 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 caregiver) can opt out of these communications at any time by contacting **VyndaLink** at 1-888-222-8475.

Print Name of Patient or Authorized Patient Representative*	Signature of Patient or Authorized Patient Representative*
Print here	Sign here
Relationship to Patient*	Date*
Print Name of Caregiver	
Print here	
Caregiver Signature	Date
Sign here	

VyndaLink ENROLLMENT FORM: HEALTHCARE PROVIDER

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SPECIAL INSTRUCTIONS	☐ PAP only (Must complete Section 2 and 3 including co-pay amount when requesting PAP only)

Fields marked with * are required.

8. Healthcare Provider Information

HCP Name (First, MI, Last)*		Practice/Institution Name*	Specialty*	
Street Address*		City*	State*	ZIP Code*
Phone*	Fax*	NPI #*	State License #*	
Office Contact Name*	Office Contact Phone*	Email		

9. Prescription Information* (Required. Please complete all boxes and include prescription when requesting a Benefits Verification, Interim Care, or Pfizer Patient Assistance Program.)

Patient Name (First, MI, Last)*	Patient Date of Birth (mm/dd/yyyy)*
☐ I attest that my patient's diagnosis was confirmed.	Please list type of diagnostic test:
Primary ICD-10 Diagnosis Code* (Required. Provide ICD-10 code)	Secondary ICD-10 Diagnosis Code

☐ 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.

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

Patient's Concurrent Medications:

Other Known Conditions:

Prescription

Refills # _____

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

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)

Pfizer Patient Assistance Program

(for eligible uninsured/underinsured 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)

10. Healthcare Provider Consent and Signature* (Required)

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.

Print Name of Healthcare Provider*

Print here

Signature of Healthcare Provider* (NO STAMPS) (dispense as written)	Date*

Sign here

OR

Signature of Healthcare Provider* (NO STAMPS) (product substitution allowed)	Date*

Sign here

If you are a NY prescriber, please use an original NY State Prescription Form.

†See terms and conditions on page 8.

‡Criteria depend on a number of factors, including the specific medicine prescribed, insurance status, and household size and income. The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and 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 provider section of the enrollment form.

VyndaLink ENROLLMENT FORM: HEALTHCARE PROVIDER

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For Healthcare Providers Fields marked with * are required.

11. Healthcare Provider HIPAA and TCPA Attestation* (Required)

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, including contacting the patient's insurer to obtain status information, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for VYNDAMAX® (tafamidis).

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, **VyndaLink**, and/or 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 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.

Signature of Healthcare Provider*	Date*
Sign here	

See next page to continue completing the provider section of the enrollment form.

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VyndaLink Interim Care†

The Interim Care program may provide new, eligible patients with up to 60 days of free VYNDAMAX® (tafamidis) shipped directly to patients who have provided a completed Interim Care program VYNDAMAX prescription 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 **VyndaLink** Interim Care program, **VyndaLink** will notify the Part D plan of the patient's enrollment in the Interim Care program.

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

12. Prescriber Acknowledgment of VYNDAMAX 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).

Prescriber Signature*	Date*
Sign here	

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

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Pfizer Rare Disease