VyndaLink Enrollment Form

VyndaLink™
Connecting Access, Reimbursement, and Education

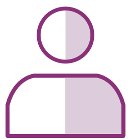
Please complete and provide this form to your healthcare provider.

If you have a prescription for VYNDAMAX™ (tafamidis) or VYNDAQEL® (tafamidis meglumine), you can complete and fax this form 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.

By enrolling in the **VyndaLink** program, patients will receive various forms of support and information to help access VYNDAMAX and VYNDAQEL, which may include the following, depending on the 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 your eligibility for and helping you access co-pay support or free drug programs
- Communicating with your healthcare providers about VYNDAMAX and VYNDAQEL and patient support activities
- Providing you with financial assistance resources and information if you are eligible
- Providing you with disease management and other educational materials, as well as information about Pfizer's products, services, and programs; this may include sending you surveys about your experience with Pfizer products, services, and programs

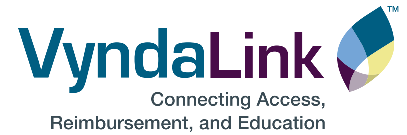


ENROLLMENT CHECKLIST **FOR PATIENTS**

- ☐ Complete all required sections marked with an asterisk * on pages 2-4
- ☐ If you are seeking financial assistance, complete all financial information in section 2 and 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 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 Patient Authorization to Share Health Information (section 7), and if interested in Personalized Patient Support, check the box in section 6
- ☐ Make a photocopy of your enrollment form, as it will not be returned to you

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

VyndaLink ENROLLMENT FORM: PATIENT



Please complete and provide this form to your healthcare provider, along with copies of both sides of your insurance cards. You can also fax this form 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.

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* ☐ OK to leave message		Language Preference	
☐ Patient Caregiver	Caregiver Name	Caregiver Phone	

2. Patient Financial Information (This information is required to search for alternate funding support and verify eligibility for the Pfizer Assistance Program† as appropriate. If you complete this section, be sure to read and sign section 4 on the next page.)

Total number of people within household (including applicant)	Total annual household income $
Please submit documentation to support the financial information you've listed. Attached is: ☐ Most recent federal tax return ☐ W-2 form ☐ Other	

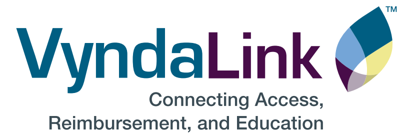
3. Insurance Information (Please include a copy of both sides of your insurance and prescription card[s].)

☐ Check here if you do **not** have insurance ☐ Check here if you have 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) or VYNDAQEL® (tafamidis meglumine) 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 insured through a Medicare Prescription Drug Plan, please include the full plan address‡:		

†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.
‡If you have a Medicare Part D Plan and are enrolled in a **VyndaLink** free drug program, **VyndaLink** may notify your Medicare Part D Plan of your enrollment.

See next page to continue completing the enrollment form.

VyndaLink ENROLLMENT FORM: PATIENT



Please complete and provide this form to your healthcare provider, along with copies of both sides of your insurance cards. You can also fax this form 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.

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

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 medicines through your insurance, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

I understand that:

Completing this enrollment form does not guarantee that I will qualify for Pfizer's assistance programs. Pfizer may contact my insurer, to help me understand my insurance coverage for certain products and may provide me support to obtain coverage through my insurer, including prior authorization and appeals assistance (if necessary and available). Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by Pfizer's assistance programs shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel Pfizer's assistance programs, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase.

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 out-of-pocket expenses for prescription drugs. I will not 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 HCP so that my HCP may share health information about me with Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation, Inc. By signing the form, 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.

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

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

5. Patient Consent to Receive Communications (optional)

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 has also agreed to receive such communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, **VyndaLink**, and/or parties acting on their behalf to contact my caregiver 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

Patient Signature	Date
Sign here	

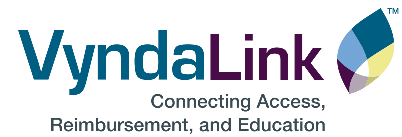
6. Personalized Patient Support Opt-in (optional)

Personalized patient support is offered through **VyndaLink** via Patient Support Navigators. You can speak with Patient Support Navigators for resources that may help with your daily life. Your Patient Support Navigators may provide information about your condition, VYNDAMAX™ (tafamidis) and VYNDAQEL® (tafamidis meglumine) medicine, or topics such as nutrition, as well as a co-pay card offer for eligible patients. Patient Support Navigators can also connect you to independent organizations that provide services such as transportation and lodging for your treatment-related appointments. These offerings may vary based on your prescribed medicine. To opt into 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 Pfizer at 1-888-222-8475.

See next page to continue completing the enrollment form.

HIPAA AUTHORIZATION FORM FOR THE DISCLOSURE OF PATIENT INFORMATION BY PERSONAL PHYSICIAN



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 health care providers ("Health Care 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 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 Health Care 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 Health Care 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. 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 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 has also agreed to receive such communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, **VyndaLink**, and/or parties acting on their behalf to contact my caregiver 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* (Print here)	Signature of Patient or Authorized Patient Representative* (Sign here)
Relationship to Patient	Date*

Please retain the original signed Authorization for your records and provide a copy to your healthcare provider.

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Pfizer Rare Disease