

Please follow the instructions in the left-hand column and print clearly.

- To receive a supply of Lyrica, you must mail this form and an original prescription to the address below.
- If you are new to *Connection to Care*, you will need to send in a New Patient Application and financial documents along with this form.
- This form is only to receive Lyrica. For any other medicines, please call 800-707-8990.
- Any medications supplied by Pfizer as a result of this order 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.

Please be sure to fill in all requested items.

 **Patient Information**

Patient Name _____

Patient Address _____ **Apartment** _____

City _____ State _____ Zip _____

Telephone Number - -

Date of Birth (month/day/year) / /

Social Security Number - -

Gender Male Female

 **Health History**

Please be sure of your answers when you fill out this section. If you are not sure about any of these items, talk to your doctor.

Allergies

No Known Allergy Penicillin Allergy Aspirin Allergy Sulfa Allergy

Other Allergy _____

Health Conditions

Diabetes Epilepsy Heart Condition Glaucoma

High Blood Pressure Thyroid Ulcer

Other Conditions _____

List all of your prescription and over-the-counter medicines.

Prescription and over-the-counter medicines _____

Pfizer reserves the right to change or cancel the Connection to Care program at any time. **By signing below, I affirm that my answers are complete and accurate to the best of my knowledge.** Additionally I consent to the submission of my prescription information, health history, and a copy of this application by the healthcare provider named below to any mail-order pharmacy that may dispense any medication for which I may qualify under the Connection to Care program.

You must sign here for your order to be filled.

X _____

Signature of patient (no photocopies or stamps) _____ **Date** _____

Privacy Statement Pfizer Inc respects your right to confidentiality of your personal and medical information. Pfizer (and companies working with Pfizer) will use the information you provide to determine your eligibility and to administer the *Connection to Care* program. Your information will not be shared with other third parties (such as outside mailing lists). Pfizer may use nonidentifiable information (such as your gender, location or age) to evaluate the *Connection to Care* program or to develop other programs and services.


Order Form

Patient Name _____

Date of Birth (month/day/year) / /

Social Security Number - -

The doctor who writes the prescription for Lyrica should fully complete this section.

▶  **Physician Information**

Name and Professional Designation of Physician		DEA # (required)	Expiration Date
Office Address (for correspondence)		Suite	Name of Clinic or Hospital (if Applicable)
City	State	Zip	Name and Title of Office Contact Person
Telephone Number		Fax Number	

By signing below, you the physician understand and agree that:

- *Connection to Care* will be shipping only Lyrica directly to the patient's home.
- Pfizer may contact the patient directly to confirm receipt of medications.
- Pfizer may change or cancel this program at any time.

The doctor **must** sign here for the order to be filled.

▶ **X** _____ Date

Signature of physician (no photocopies or stamps)

Lyrica is a controlled substance, Schedule V. State restrictions may apply.

Mail completed form and original prescription to:

Pfizer Connection to Care Program
P.O. Box 66585
St. Louis, MO 63166-6585

If you have any questions, concerns, or need help with this form, please call **800-707-8990**.



New Patient Application

READ THE INSTRUCTIONS ON THE OTHER SIDE FIRST. PLEASE PRINT CLEARLY IN THE SHADED AREAS. MAIL THE ORIGINAL APPLICATION TO THE ADDRESS BELOW.

PATIENT INFORMATION

Patient name _____

Patient address _____ **Apartment** _____

City _____ **State** _____ **Zip** _____

Telephone number

Date of birth (month/day/year) / /

Gender Male Female **Ethnic origin (optional)** Asian Black Hispanic White Other

Are you in any benefit program that helps pay for prescription drugs?
SEE THE OTHER SIDE FOR EXAMPLES. IF YES, YOU CANNOT RECEIVE MEDICATION FROM THIS PROGRAM. Yes No

Are you enrolled in Medicare? Yes No **Are you enrolled in a Medicare prescription drug coverage program (also known as "Part D")?** Yes No

Did you file a Federal tax return for the most recent tax year?
IF NO, YOU MUST SIGN BOTH THE PATIENT INFORMATION SECTION AND THE REQUEST FOR IRS VERIFICATION BELOW. Yes No

Total yearly income for your entire household \$ _____ **Number of dependents in your household** _____
(INCLUDING YOURSELF AND YOUR SPOUSE IF MARRIED)

PFIZER MAY CHECK THE INFORMATION ON YOUR APPLICATION. WE MAY ASK YOU FOR MORE FINANCIAL AND INSURANCE INFORMATION. PFIZER RESERVES THE RIGHT TO CHANGE OR CANCEL THE CONNECTION TO CARE PROGRAM AT ANY TIME.

By signing below, I affirm that my answers, and my proof-of-income documents, are complete and accurate to the best of my knowledge.

Original patient signature for application _____ **Date** _____

May Pfizer use your information to contact you about your experience with the Connection to Care program? Yes No

REQUEST FOR IRS VERIFICATION THAT YOU DID NOT FILE A TAX RETURN

If you did not file a Federal tax return for tax year 200_, sign again below in this section to agree that:

- You are asking the IRS to send confirmation to Pfizer that you did not file a Federal tax return for the tax year 200_.
- The IRS does not control how Pfizer uses this information.
- The IRS may call you to make sure you want to share this confirmation.

IRS: PLEASE SEND VERIFICATION TO Pfizer Connection to Care PO Box 66557 St. Louis, MO 63166-6557

Patient signature for IRS request _____ **Date** _____

HEALTHCARE PROVIDER TO BE COMPLETED BY THE PRACTITIONER WHO WRITES THE PRESCRIPTION

Name and professional designation of healthcare provider _____ **DEA # (if none available, state license #)** _____ **Expiration date** _____

Name of clinic or hospital (if applicable) _____ **Name and title of office contact person** _____

Shipping address (We cannot accept a PO Box) _____ **Suite** _____ **Telephone** _____ **Fax** _____

City _____ **State** _____ **Zip** _____

By signing below, you the healthcare provider understand and agree that:

- Any medications supplied by Pfizer as a result of this order 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.
- Pfizer may contact the patient directly to confirm receipt of medications.
- Pfizer may change or cancel this program at any time.

Original signature of practitioner _____ **Date** _____

DEA #
LIC. #

Date

Patient

Name _____

DOB _____

Address _____ City _____ St. _____ Zip _____

Rx

Qty:

Sig:

(X) Dispense as Written, signed by provider

Refill _____ times

VOID if Not Signed by Provider