ENROLLMENT FORM: PATIENT APPLICATION

Please complete the form where applicable and return via mail or fax.

Phone 1-877-744-5675 or Fax 1-800-708-3430 PO Box 220582, Charlotte, NC 28222-0582

Please check the appropriate Pfizer product:

- ☐ Sutent® (*sunitinib malate*) capsules
- ☐ Aromasin® (*exemestane*) tablets
- ☐ Emcyt® (*estramustine phosphate sodium*) capsules

SUTENT PATIENT SUPPORT PROGRAM

☐ By checking this box, you would like to receive more info about the **free** Sutent Patient Call Center to help supplement the info you receive from your health care provider about Sutent and provide you an added support resource while on treatment.

Patient Name:	Sex: ☐ Male ☐ Female
Patient Address:	E-mail:
City:	State: Zip Code:
Telephone (Day): (____) ____ – ______	(Evening): (____) ____ – ______
Date of Birth (DOB): ___ /___ /___	U.S./Puerto Rico/U.S.V.I. Resident: ☐ Yes ☐ No

INSURANCE INFORMATION (Include all insurance policies)

Do you have insurance? ☐ Yes ☐ No *(If yes, complete the information below or attach a photocopy of insurance card)*

Primary Insurance Co. Name:	Phone #: (____) ____ – ______	
Policy Holder Name:	Policy Holder DOB: ___ /___ /___	
Policy Holder SSN: _____–____–______	Policy #:	Group #:
Prescription Card Name:	Phone #: (____) ____ – ______	
Policy #:	Group #:	
Secondary Insurance Co. Name:	Phone #: (____) ____ – ______	
Policy Holder Name:	Policy Holder DOB: ___ /___ /___	
Policy Holder SSN: _____–____–______	Policy #:	Group #:
Prescription Card Name:	Phone #: (____) ____ – ______	
Policy #:	Group #:	

PATIENT FINANCIAL INFORMATION

Total Number of People Within Household (including applicant): ____________

Total Annual Income for Entire Household: $ ____________ *(The current annual household income includes current annual salary, Social Security, unemployment insurance benefits and workers' compensation)*

Please submit documentation to support the financial information

Attached is: ☐ Most recent federal tax return (1040 form) ☐ W-2 form ☐ Other

We must receive proof of income to determine eligibility for assistance.

If you are required to file a federal tax return, please provide a signed copy. Proof of income may include documents such as: copy of most recent federal tax return, W-2 form(s), 1099 form, Social Security Award Letter or Check, or copy of three most recent pay stubs.

Patient Declaration – By signing below, 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 application form does not guarantee that I will qualify for the First Resource Program.
- Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medications supplied with the First Resource Program shall not be sold, traded, bartered or transferred.
- Pfizer reserves the right to change or cancel the First Resource Program at any time.
- The support provided in this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by Pfizer through the First Resource Program:

- I will promptly contact First Resource Program if my financial status or insurance coverage changes.
- I will not seek to have the medicine(s) or any cost from it (them) counted in my Medicare Part D out-of-pocket expenses for prescription drugs.
- I will not seek reimbursement or credit for any costs associated with 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 medicine(s) through the First Resource Program.

Pfizer and Pfizer Patient Assistance Foundation (PPAF) understand your personal and health information is private. The information you provide will only be used by Pfizer, PPAF and parties acting on their behalf to send you the materials you request and other helpful information and updates on the First Resource Program.

☐ By checking this box, I also agree that Pfizer and PPAF and companies acting on their behalf may send me materials about other health conditions, use my information to develop or improve products and services, or contact me in the future about my experience with the First Resource Program or other health-related topics.

Patient Signature *(Parent or Guardian, if under 18 years of age)*	X	Date:

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ENROLLMENT FORM: HEALTHCARE PROVIDER APPLICATION

Please read all information and print clearly.

PRESCRIBER INFORMATION *(To be completed by the provider)*		
Prescriber Name & Title:		NPI #:
Payer Specific #:		Tax ID #:
State License #:		DEA #:
Contact Name:		
Name of Facility:		
Facility Address:		
City:	State:	Zip Code:
Phone: (_____) _____ – ______	Fax: (_____) _____ – ______	
Prescriber E-mail Address:		
Please provide diagnosis and specific ICD-9 code:		

PRESCRIBER CERTIFICATION

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I will notify First Resource immediately if the Pfizer product is no longer medically necessary for this patient's treatment. **I certify that the Pfizer product is medically necessary for this patient and I will be supervising the patient's treatments.** I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification and insurance information to Pfizer and their agents and representatives. I understand that any information provided is for the sole use of Pfizer and their agents and representatives to verify my patient's insurance coverage, to assess, if applicable, patient's eligibility for participation in the patient assistance program and to otherwise administer the First Resource program. I understand that application to the patient assistance program does not guarantee that assistance will be obtained. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the patient assistance program, and I agree to immediately notify a First Resource representative if I become aware of changes in the patient's insurance status. I agree that First Resource may contact me for additional information relating to this application either by fax or any other form of communication, including but not limited to e-mail and telephone. I understand that I am under no obligation to prescribe any Pfizer product and that I have not received nor will I receive any benefit from Pfizer or their agents or representatives for prescribing a Pfizer product. I agree that I will not submit claims for product provided by the Patient Assistance Program

Pfizer and Pfizer Patient Assistance Foundation (PPAF) understand your information is private. Any information you provide will only be used by Pfizer, PPAF and parties acting on their behalf to administer the First Resource Program and to comply with applicable legal requirements.

☐ By checking this box, I also agree that Pfizer and PPAF and companies acting on their behalf may contact me about my experience with the First Resource Program to help improve services.

Prescriber Signature:	X	Date:

PATIENT INFORMATION		
First Name:	Last Name:	
Date of Birth: ____/____/____	Phone #: (_____) _____ – ______	
Patient Address:		
City:	State:	Zip Code:
Shipping Address *(If different than above)*:		
City:	State:	Zip Code:

PRESCRIPTION *(For full prescribing information, go to www.pfizeroncology.com)*	
Directions:	Refill: ______ times
Drug Allergies: ☐ Yes ☐ No If yes, please specify:	
☐ **Sutent:** _____ mg, 28-day supply	☐ **Aromasin:** 25 mg, 90 day supply ☐ **Emcyt:** _____ mg, 90 day supply

Prescriber Signature:	X	Date:

Please fax completed prescription form to First Resource at (800) 708-3430. Thank You.
Prescription valid for one year.

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