This form must be filled out by a health care provider.

Factor Savings Card - Medical Benefit Option

Please complete ALL fields with black ink and fax ALL documents to 1-844-250-7194.

Please send a copy of the patient's Explanation of Benefits and signed HIPAA form.

For help, please call 1-877-329-8294. Available hours are Monday through Friday, 8 AM to 5 PM ET.

Select a Payment Option

Choose a payment option: □ Check here if applying for a Virtual Debit Card

□ Check here if applying for reimbursement via check (Check will be sent to Financial/Billing Site location listed below.)

Financial/Billing Site Information

Contact Name:	Contact Phone Number:	
Billing Site Name:		
City:	State:	ZIP Code:
Phone Number:	Fax Number:	

Infusion Site Information

Contact Name:	Contact Phone Number:	
Infusion Site Name:		
City:	State:	ZIP Code:
Phone Number:	Fax Number:	

Patient Information

Enter Factor Savings Card Member ID Number:		□ Copy of Explanation of Benefits Attached		
Last Name:		First Name:		MI:
Gender: □ Male □ Female □ Decline to Answer	Date of Birth:	Address:		
City:		State:	ZIP Code:	

Physician Information

Physician Name:	Address:	
City:	State:	ZIP Code:
Phone Number:	Fax Number:	

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, and 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 Pfizer Factor Product.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, Pfizer Hemophilia Connect, 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 my permission to receive calls related to these services from Pfizer, Pfizer Hemophilia Connect, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

Health Care Provider's Signature Date

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Patient Authorization

Please complete ALL fields with black ink and fax ALL documents to 1-844-250-7194.

Patients must read this and sign the acknowledgment below before they can participate in the Program.

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 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 the [PROGRAM at INSERT WRITTEN ADDRESS AND PHONE. 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, the PROGRAM, 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, Hub, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Hub, 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 Hub at patient support #.

Patient Printed Name

Patient Signature Date

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