Wyeth

Patient Application

Wyeth Pharmaceutical Assistance Foundation
P.O. Box 66762
St. Louis, MO 63166-6762
Questions: Call 1-800-568-9938

ELIGIBILITY REQUIREMENTS:

Thank you for your interest in the Wyeth Pharmaceutical Assistance Foundation Patient Assistance Program. To be eligible for this program:

- Your total family household income must be at or below 200% of the Federal Poverty Level
- You must be a resident of the United States or Puerto Rico
- You cannot have any insurance or receive any benefits that help pay for prescription drugs, such as:
  - Private insurance
  - Medicaid
  - Medicare prescription drug coverage (Medicare Part D)
  - State-sponsored prescription drug assistance programs
  - Employee, military, retirement, or pension program drug coverage

Pharmacy discount cards or drug company assistance programs are not insurance coverage. If you participate in these programs, you may still qualify. If your application is approved, we will send up to a three-month supply of medication to you or your health care provider.

WHAT YOU NEED TO SEND US

1. **This application form** filled out and signed by both you and your health care provider.
2. **Your original prescription form** signed by your health care provider.

Place all required documents together in a stamped envelope and mail to:

Wyeth Pharmaceutical Assistance Foundation
P.O. Box 66762
St. Louis, MO 63166-6762

If you have questions or need help with your application, please call a Wyeth Pharmaceutical Assistance Foundation representative at 1-800-568-9938.

WYETH PRESCRIPTION MEDICINES

Effexor® (venlafaxine HCl) Tablets 25 mg, 37.5 mg, 50 mg, 75 mg & 100 mg

Effexor XR® (venlafaxine HCl) Extended-Release Capsules 37.5 mg, 75 mg & 150 mg

Phospholine Iodide® (echothiophate iodide for ophthalmic solution) 6.25 mg per 5 mL

Premarin® (conjugated estrogens tablets, USP) 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg & 1.25 mg

Premarin® (conjugated estrogens) **Vaginal Cream** 0.625 mg/g

Premphase® (conjugated estrogens/ medroxyprogesterone acetate tablets) 0.625 mg/5 mg

Prempro® (conjugated estrogens/ medroxyprogesterone acetate tablets) 0.3 mg/1.5 mg, 0.45 mg/1.5 mg, 0.625 mg/2.5 mg & 0.625 mg/5 mg

Pristiq® (desvenlafaxine) Extended-Release Tablets 50 mg & 100 mg

Protonix® (pantoprazole sodium) Delayed-Release Tablets 40 mg

Trecator® (ethionamide tablets, USP) 250 mg

Medications available through the Patient Assistance Program are subject to change at any time.

PATIENT DECLARATION – PLEASE READ

I authorize Wyeth Pharmaceuticals and the Wyeth Pharmaceutical Assistance Foundation to use this information to assess my eligibility for participation in the Patient Assistance Program ("Program"), including the audit of my medical records and/or by contacting me directly to confirm my eligibility or receipt of drug and matters related to such program. I understand that this assistance is temporary and that this Program may be discontinued or changed at any time. I understand that Wyeth Pharmaceuticals and the Wyeth Pharmaceutical Assistance Foundation will use my personal information in connection with the operation of the Program and issues related to such program. I certify I do not have the ability to pay for my medication, earn less than 200% of the current HHS Poverty Guidelines, am a U.S. resident, and that I have no government or private insurance to pay for my medication. I have read and agree to all terms of the Patient Declaration on this application. I also certify that I do not have other sufficient financial resources or assets to pay for the medication requested or that paying for the medication from my own resources or assets would cause me severe financial hardship. I attest the information I have provided is correct and complete.

I authorize the Supplier of the Program to disclose to Wyeth Pharmaceuticals and the Wyeth Pharmaceutical Assistance Foundation all personal information relating to my medical condition, treatment and insurance coverage needed to administer my participation in the Program. I understand that if I refuse to sign this authorization, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment or affect my insurance enrollment or eligibility for insurance benefits. I understand that I may cancel this authorization at any time by mailing a letter to the Program. Canceling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed but will not affect disclosures made before that time. I understand that once my personal information is disclosed to Wyeth Pharmaceuticals and the Wyeth Pharmaceutical Assistance Foundation, federal privacy laws may no longer protect the information from further disclosure. This authorization expires at the end of my participation in the Program.

Fill Out the APPLICATION *(other side)*	Mail APPLICATION COMPLETED AND SIGNED ORIGINAL PRESCRIPTION NO PHOTOCOPIES

Wyeth Pharmaceutical Assistance Foundation

P.O. Box 66762
St. Louis, MO 63166-6762
Questions: Call 1-800-568-9938

Please attach written prescription

All fields must be completed

Wyeth

Patient assistance application

Section 1 – Licensed Prescriber			
Licensed Prescriber Name:	State License #:	Phone: ( ) Fax: ( )	
Address:	City:	State:	Zip:

Section 2 - Medication Information

Medication should be sent to: Licensed Prescriber's office ☐ Patient's address ☐
(Phospholine Iodide must be sent to Licensed Prescriber)

Is the patient allergic to medications? No ☐ Yes ☐ Please list all:

List all medications the patient is currently taking:

Licensed Prescriber Attestation: I request the medication to be provided to me for the following patient who certified that he/she is a U.S. Resident earning less than 200% of the current HHS Poverty Guidelines and is not eligible for any third-party payment (Medicaid, Insurance, Government Agencies) for the medication requested. I agree that if this application is approved, the medication will be provided to the patient identified below free of charge, i.e., neither the patient nor any third party will be billed for the medication. I have obtained and maintain a valid HIPAA Authorization form from the following patient pertaining specifically to the Wyeth Patient Assistance Program.

Licensed Prescriber Signature: **X**	Date:

Section 3 - Patient Information			
Patient Name:		Social Security, Green Card or Visa Number: - -	
Street Address:		Date of Birth: / /	Male ☐ Female ☐
City	State	Zip	Phone: ( )

Section 4 – Enrollment Information			
Number of Household members (including self) **(circle one)** 1 2 3 4 5 6 7 other	U.S. Resident Yes ☐ No ☐	Are you a Veteran of the U.S. Armed Forces? Yes ☐ No ☐	Are you Legally Disabled? Yes ☐ No ☐

List All Sources, Gross Monthly Amounts

Salary/Wages $____________ Social Security $____________

Social Security Disability $____________ Pension/Retirement $____________

Child Support/Alimony $____________ Unemployment/ Work Comp $____________

Total Gross Household Income Monthly: ____________

Prescription Drug Coverage		
Prescription Drug Coverage: Private / Commercial Insurance	Yes ☐	No ☐
Medicaid Drug Coverage	Yes ☐	No ☐
Medicare Drug Coverage / Medicare Part D	Yes ☐	No ☐
State Elderly Drug Assistance	Yes ☐	No ☐

Total Patient Assets: $__________ (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)

Section 5 – Patient Signature	
Patient's or Legal Guardian's Signature: I certify I do not have the ability to pay for my medication, earn less than 200% of the current HHS Poverty Guidelines, am a U.S. resident, and that I have no government or private insurance to pay for my medication. I have read and agree to all terms of the Patient Declaration on page 1 of this application. **X**	Date:

Wyeth Patient Assistance Program Authorization Form

This Patient Assistance Program Authorization Form authorizes your health care provider to disclose your health and medical information to Wyeth and to the Wyeth Pharmaceutical Assistance Foundation and their respective employees, representatives and agents or its suppliers (collectively, "**Wyeth**") in connection with your application to the Wyeth Patient Assistance Program (the "**Wyeth PAP**") as required by the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("**HIPAA**").

Authorization.

I, ____ **[First, Middle and Last Name]**, hereby authorize ____ **[Name of Physician or Medical Group]** ("**Health Care Provider**") to disclose my individually identifiable health and medical information described below to Wyeth solely for the authorized purposes described in this authorization form.

Description of Health and Medical Information That May Be Disclosed.

My Health Care Provider may disclose individually identifiable health and other information that supports my application to the Wyeth PAP and that may include my name, address, date of birth, social security number, financial information, medical records and the specialty of my health care provider.

Authorized Purposes.

The authorized purposes are: (1) to permit Wyeth to evaluate my eligibility for participation in the Wyeth PAP; and (2) if Wyeth, in its sole discretion, approves my request to participate, for Wyeth's administration of my participation in the Wyeth PAP.

Expiration of Authorization.

My authorization shall expire (1) when Wyeth does not approve my application for participation in Wyeth's PAP, or (2) at the conclusion of my participation in the Wyeth PAP, whichever is earlier.

Acknowledgments.

(1) I understand that Wyeth is not an entity covered by HIPAA and related federal privacy regulations and that my medical and health information may be subject to redisclosure by Wyeth and no longer protected by such federal privacy regulations. I further understand and agree that Wyeth may retain my medical and health information as disclosed to Wyeth by my Health Care Provider under this authorization after this authorization expires for purposes related to the administration of the Wyeth PAP.

(2) I understand that I may refuse to sign this authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my Health Care Provider; or to seek payment or my eligibility for benefits. However, I understand that I may not participate in the Wyeth PAP if I refuse to sign this authorization form.

(3) I understand that I may revoke my authorization at any time by providing a written notice of same to my Health Care Provider that refers to (or with a copy of) this authorization form, or as set forth in my Health Care Provider's Notice of Privacy Practices (if any). However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my Health Care Provider to Wyeth in reliance on this authorization.

____ ____________________
Signature of Patient or Patient's Personal Representative Date

____
Patient's Name

____ ____________________
Name of Personal Representative (if applicable) Relationship to Patient

HEALTH CARE PROVIDER MUST GIVE PATIENT AND/OR PATIENT'S REPRESENTATIVE A SIGNED COPY

Health Care Provider has verified Patient Representative's authority to act on Patient's behalf ______ (check)