MAINTAIN™

Medicines Assistance for
Those who Are In Need

Pfizer

866-706-2400

For continuation of Pfizer medicines during unemployment

Temporary Program – Enrollment accepted until December 31, 2009

Program Criteria:

1. You reside in the United States *AND* became unemployed starting on or after January 1, 2009.
2. You were taking a Pfizer medicine for at least three months prior to your unemployment status and enrollment in program.
3. You have no insurance coverage or benefits for prescription medicines.
4. As a result of your unemployment and lack of insurance, you will be unable to pay for your medicines without this program.
5. You have proof of your unemployment. Examples include: Your State Unemployment Benefits Confirmation Letter, Unemployment Benefit Check Stub, Previous Employer Termination Letter or other.
6. Your spouse or dependents may also qualify. Please call 866-706-2400 for instructions.
7. If accepted, your medicines will be shipped in 90-day supplies directly to your home address for up to one year.

Please allow 2-3 weeks for processing. Please call 866-706-2400 if you have any questions.

STEP 1 Fill in all shaded areas of this application form.

STEP 2 Place your completed and signed application, copy of your proof of unemployment and controlled substance prescription / ID (as needed) in a stamped envelope.

STEP 3 Mail to:
Pfizer MAINTAIN™
PO BOX 66549
St. Louis, MO 63166-6549

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Patient Name: **Date of Job Loss:** ___/___/___

Patient Street Address *(No PO Box)*:

City: **State:** **Zip Code:**

Telephone: (___) ___ – ____ **Date of Birth: (MM/DD/YY):** ___/___/___

E-Mail Address: **Gender:** ☐ Male ☐ Female

2 PRESCRIPTION INFORMATION

Please attach original prescriptions for controlled substances and include a copy of your photo identification.
For all other medicines, please fill out the prescription transfer information below.

Pharmacy Name: **Pharmacy Telephone:** (___) ___ – ____

Doctor Name: **Doctor Telephone:** (___) ___ – ____

Drug Name:		**Strength:**		**Prescription Number:**	
Drug Name:		**Strength:**		**Prescription Number:**	

Allergies: ☐ No Known Allergy ☐ Penicillin Allergy ☐ Aspirin Allergy ☐ Sulfa Allergy ☐ Other _____

Health Conditions: ☐ Diabetes ☐ Epilepsy ☐ Heart Condition ☐ Glaucoma ☐ High Blood Pressure
☐ Thyroid ☐ Ulcer ☐ Other _____

List other prescription and over-the-counter medications:

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Patient Declaration – By signing below, I affirm that my answers are complete, true and accurate to the best of my knowledge.

I understand that:

- *Pfizer MAINTAIN*™ program is a temporary program and enrollments will be accepted until December 31, 2009.
- Completing this application form does not ensure that I qualify for *Pfizer MAINTAIN*™
- Pfizer may verify the accuracy of the information I have provided and may ask for more insurance or unemployment information.
- Any medications supplied with the *Pfizer MAINTAIN*™ program shall not be sold, traded, bartered or transferred.
- Pfizer reserves the right to change or cancel the *Pfizer MAINTAIN*™ program at any time.

I certify and attest that if I receive medicine(s) provided by the Pfizer MAINTAIN™ program:

- I currently do not have any prescription drug coverage and would have not been able to pay for my medicines and continue my therapy, due to my unemployment and uninsured status, without this program.
- I have had a valid prescription for a Pfizer medicine for at least 3 months prior to my unemployment.
- I will promptly contact the *Pfizer MAINTAIN*™ program if my unemployment status or insurance coverage changes.

Pfizer Patient Assistance Foundation understands your personal and health information is private. The information you provide will only be used by Pfizer and parties acting on its behalf to send you the materials you requested and other helpful information and updates on the *Pfizer MAINTAIN*™ program

☐ By checking this box, I also agree that Pfizer Patient Assistance Foundation or companies acting on its 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 *Pfizer MAINTAIN*™ program or other health-related topics.

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

Pfizer MAINTAIN™ is part of Pfizer Helpful Answers®, a joint program of Pfizer Inc & the Pfizer Patient Assistance Foundation.