VyndaLink
Connecting Access, Reimbursement, and Education

VyndaLink® Enrollment Form

TELEPHONE: 1-888-222-8475 FAX: 1-888-878-8474 ADDRESS: VyndaLink, PO Box 221296, Charlotte, NC 28222

Program Overview

VyndaLink is a personalized patient support program that offers resources for patients prescribed VYNDAMAX® (tafamidis).*

We provide reimbursement support as well as help identifying financial assistance options that may be available for eligible patients who are unable to afford their co-payment.

The Pfizer Patient Assistance Program†

To be considered for the Pfizer Patient Assistance Program, you must:

- Be uninsured or government insured and unable to afford your co-payment. Government insurance includes, but is not limited to, Medicare, Medicaid, Champus/TRICARE and VA
  - Commercially insured patients (e.g., insurance through your job or through a Federal Employer Plan) regardless of insurance coverage are not eligible
- For Medicare Part D/Medicare Advantage Patients Only:
  - Enroll in the *Medicare Prescription Payment Plan*‡ AND
  - Confirm that you have not met your annual out-of-pocket costs (and therefore do not yet have a $0 co-payment for covered medicines)
- Work with your physician's office, pharmacy, and/or insurance company to understand your co-payment and total prescription costs for the year in which you are requesting assistance AFTER:
  1. Prior authorization is obtained (if required by your insurer) AND
  2. Enrolling in the Medicare Prescription Payment Plan (for Medicare Part D/Medicare Advantage Patients only)
- Have an inability to afford your prescription costs and attest to this
- Have an FDA-approved diagnosis for the Pfizer product(s) prescribed
- Meet the income requirements – Your annual household pre-tax income cannot exceed 300% of the Federal Poverty Level, adjusted for household size
- Be a resident of the United States (US) or an applicable US territory
- Have a valid prescription written by a healthcare provider licensed in the US or an applicable US territory and be treated in the outpatient setting of care

Eligibility rules are subject to change at any time.

How to Enroll

Download the enrollment form at https://www.VyndaLink.com/patient/resources.
Please use one of the options below to complete and submit the VyndaLink Enrollment Form:

Patients can complete and sign their portion of the form online at VyndaLink.com **OR** they can take their completed portion of the Enrollment Form to their healthcare provider's office so that both the patient's and the provider's sections can be faxed or uploaded directly to VyndaLink

Upload/submit the fully completed form or required documents at www.patientsupportnow.org using patient support code 8888788474

- Preferred web browsers for submitting documents are Safari, Microsoft Edge, or Google Chrome

Providers may complete electronically online at the VyndaLinkportal.com (registration required)

Fax to:
1-888-878-8474

or

Mail to:
VyndaLink
PO Box 221296,
Charlotte, NC 28222

Important Instructions

- **You must complete all required fields, which are identified with an asterisk**
- If there is any information missing, VyndaLink may contact you as they cannot complete your request without all required information
- Be sure to sign and date all pages where indicated
- Photocopies of the patient's insurance card and prescription card must be submitted. Be sure to copy both the front and back of each card

*The same VyndaLink support offerings available to patients prescribed VYNDAMAX may also be available to patients prescribed VYNDAQEL® (tafamidis meglumine).
†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡The Pfizer Patient Assistance Program requires prior enrollment in the *Medicare Prescription Payment Plan* for products covered and reimbursed by Medicare Part D/ Medicare Advantage Plans. Contact your prescription health insurance plan to learn more.

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FOR PATIENTS – Please complete the form where applicable and return via mail or fax. All pages must be returned to VyndaLink.

☐ **Check here if reapplying for the Pfizer Patient Assistance Program.†**

1 PATIENT INFORMATION (*REQUIRED)

First Name* _____ MI ____ **Last Name*** _____ **Date of Birth** (mm/dd/yyyy)* _____ **Gender*** ☐ Male ☐ Female ☐ Other

Address* _____ **City*** _____ **State*** _____ **ZIP*** _____

Primary Phone* _____ ☐ H ☐ M ☐ W Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Preferred Language If Not English: _____

Email _____

Alternate Contact _____ Relationship to Patient _____ Phone _____

Email _____

1A REQUIREMENT PRIOR TO REQUESTING ASSISTANCE

Your VYNDAMAX prescription must be sent to the Specialty Pharmacy Provider for a benefits verification/test claim and/or you or your healthcare provider must contact your insurance plan directly to obtain your co-payment amount, your out-of-pocket maximum, and amount met toward your out-of-pocket maximum. If you and your healthcare provider do not know which Specialty Pharmacy is in-network with your insurance plan, check here to ask VyndaLink for help: ☐ I do not know who my in-network Specialty Pharmacy is

2 INSURANCE INFORMATION (*REQUIRED) – ☐ Check here if you are reapplying and your insurance information has not changed ☐ Check here if you have no insurance

NOTE: Patients with commercial insurance are not eligible for the Pfizer Patient Assistance Program, even if the medication is not covered by the commercial insurance plan.

Check all that apply.

I am covered by this insurance plan: ☐ Commercial ☐ Medicare Part A/B only ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid ☐ VA benefits ☐ Other (please specify) _____ ☐ None

My provider or pharmacy has reviewed my insurer-required product costs with me and I certify that I am unable to afford this.* ☐ Yes ☐ No
(If Yes, the five fields below are required and can be completed by either you, your healthcare provider, or both.)

Insurer-Required Co-payment _____ Date _____ Specialty Pharmacy Provider _____

Out-of-Pocket (OOP) Maximum for Prescriptions _____ Amount Met Toward OOP Max _____

	Primary Medical (e.g., Medicare A/B)*	Primary Prescription Insurance (e.g., Medicare D)*	Secondary Prescription Insurance
	(*REQUIRED only if front and back copies of insurance card[s] are NOT provided)		
Policyholder Name*			
Insurance Name*			
Insurance Phone*			
Policy ID#*			
Group #*			
BIN #*			
PCN #*			
Medicare Part D Insurance (*REQUIRED for all Medicare Part D patients) – Address	City	State	ZIP

2A CERTIFICATION FOR MEDICARE PART D PATIENTS (*REQUIRED if applying for the Patient Assistance Program)

By signing below, I certify that I:

- Have enrolled in the Medicare Prescription Payment Plan (allows patients to pay their prescription drug costs in capped monthly payments instead of all at once),
- Understand my prescription costs after my healthcare provider has obtained Prior Authorization (if required by my insurer) and that, once I meet my out-of-pocket maximum, I will have to pay $0 for covered, brand medicines for the remainder of the year,
- Have NOT paid my $2,000 total (including deductible) prescription costs for the year for which I am requesting assistance (my out-of-pocket maximum has not been met),
- Cannot afford my prescription cost for the Pfizer Product(s) prescribed.

SIGN X _____ _____ _____

Patient Signature* (Patient or patient representative must be 18 years or older)‡ Patient representative name (please print)§ **Date***

If signed by patient representative, you must indicate below the authority to act on behalf of patient¶:

☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

3 PATIENT FINANCIAL INFORMATION NOTE: We must receive proof of income and/or Authorization for Electronic Income Verification (below) to determine eligibility for assistance. (*REQUIRED)

Total Number of People Within Household (including applicant)* _____ **Total Pre-tax Annual Household Income* $** _____

If you choose not to consent to Electronic Income Verification in Section 4, you must submit income documentation for all contributing household members to support the financial information you've listed. Attached is: ☐ Most recent federal tax return (1040/1040-SR form) – **Required unless tax return is not filed** ☐ W-2 form ☐ Other

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.
‡Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
§NOT required if patient signs.
¶Required if patient representative signs.

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

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FOR PATIENTS

4 PATIENT AUTHORIZATION FOR ELECTRONIC INCOME VERIFICATION (Optional, but may reduce application review time)

By signing and dating below, I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Reporting Act, authorizing Pfizer Inc. to obtain information from my credit profile or other information from Experian® Income View℠. I authorize Pfizer Inc. to obtain such information solely for the purpose of determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Pfizer Patient Assistance Program financial screening process. I understand that I am entitled to a copy of this Authorization upon request. This Authorization shall be valid from the date of the signature on this form through the enrollment period (unless a shorter timeframe is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to VyndaLink at PO Box 221296, Charlotte, NC 28222, but that this cancellation will not apply to any information already used or disclosed through this Authorization. Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements, and agree to the outlined terms.

SIGN X _____ _____ _____

Patient Signature* (Patient or patient representative must be 18 years or older)‡ | Patient representative name (please print)§ | **Date***

If signed by patient representative, you must indicate below the authority to act on behalf of patient¶:

☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

5 PATIENT PRIVACY NOTICE AND CONSENT TO PROCESS HEALTH INFORMATION (*REQUIRED)

By checking the box below, you understand that Pfizer Inc., VyndaLink, at PO Box 221296, Charlotte, NC 28222, Pfizer's affiliates, and its vendors (collectively, "Pfizer") will use the health information you and your healthcare providers provide us to provide you with the Patient Support Activities. You have the right to withdraw these permissions at any time and can do so by contacting VyndaLink at PO Box 221296, Charlotte, NC 28222 or by calling 1-888-222-8475, Monday-Friday, 9 AM-6 PM ET. You can find more information about how Pfizer Inc. handles your personal information in our Privacy Policy at pfizer.com/privacy.

By using the boxes below, you can also agree to permit Pfizer to use the information you provide for additional specified purposes:

☐ I agree to permit Pfizer to use the information I provide through this program to conduct related research to learn more about wild-type and hereditary forms of transthyretin amyloid cardiomyopathy (ATTR-CM), and help other individuals with ATTR-CM better manage their condition.

☐ I agree to permit Pfizer to use the information I provide through this program for additional purposes that are not considered necessary/compatible with the purposes above (e.g., marketing, promotions, sales, research, merchandising, and fundraising activities/communications).

I understand that I have the right to withdraw my consent by calling VyndaLink at 1-888-222-8475, and that if I withdraw my consent it will be effective for any future disclosures but will not affect disclosures already made.

☐ ***I understand and consent to the terms of the Privacy Notice and Consent to Process Health Information.**

6 PATIENT CONSENT TO RECEIVE CALLS AND TEXTS (*REQUIRED)

By providing my mobile number and checking the box below, I or my alternate contact agree to receive calls and texts from Pfizer or parties acting on its behalf, to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, refill reminders from VyndaLink, information and other Patient Support Activities (such as co-pay support or free drug programs) and for other non-marketing purposes (such as enrollment status and shipping updates) at the telephone number(s) I or my alternate contact provide.

Please enter the mobile number you would like to enroll for texting (_____) _____ – _____

☐ ***I or my alternate contact agree to receive calls and texts from Pfizer or parties acting on its behalf as stated.**

I understand that I (and, if applicable, my alternate contact) can opt-out of these communications at any time by contacting VyndaLink at 1-888-222-8475. I understand that my consent is not required and is not a condition of purchasing any goods or services from Pfizer. Message and data rates may apply. Complete terms can be found at rebrand.ly/dxzxpa and Pfizer's privacy policy at www.pfizer.com/privacy. Text STOP to opt-out.

7 PFIZER PATIENT ACCESS COORDINATOR OPT-IN

When you enroll in VyndaLink, you have the option to be contacted by a Pfizer Patient Access Coordinator (PAC), who can help you understand your insurance benefits and navigate the process to access your VYNDAMAX® (tafamidis) prescription. Pfizer PACs are Pfizer employees and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. Pfizer PACs are very familiar with access and reimbursement requirements for VYNDAMAX, and the Pfizer PAC assigned to you will coordinate with VyndaLink and you on your journey to starting therapy (although you will still need to contact VyndaLink directly if you are seeking financial assistance). Working with a Pfizer PAC is optional. Even if you choose not to opt-in for this support, you may still access all patient support programs you are eligible for by working with a case manager at VyndaLink.

☐ By checking this box, I request Pfizer PAC support and agree to receive telephonic communications from the Pfizer PAC assigned to my case as described above. I understand that my consent is not required or a condition for purchasing any Pfizer goods or services. I understand that I can opt-out of support from, and communications with, the Pfizer PAC at any time by contacting VyndaLink at 1-888-222-8475.

8 PFIZER PATIENT ASSISTANCE PROGRAM† CERTIFICATION (*REQUIRED)

The information you provide will be used by Pfizer Inc. ("Pfizer"), the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

Patient Declaration - By signing below, I certify that I cannot afford my medication, and 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 enrollment form does not guarantee that I will qualify for the Pfizer Patient Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by the Pfizer Patient Assistance Program shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Pfizer Patient Assistance Program, Pfizer will notify my Part D Plan of my enrollment in the Pfizer Patient Assistance Program. If I am a commercially insured patient applying after January 1, 2024, I cannot receive assistance through the Pfizer Patient Assistance Program even if my prescription is not covered by the commercial insurance plan. Any employer-funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that I am a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan.

I certify and attest that if I receive medicine(s) provided by Pfizer through the Pfizer Patient Assistance Program: I will promptly contact the Pfizer Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D true out-of-pocket costs (TrOOP) for prescription drugs. I will not submit claims, seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payer, including Medicare Part D plans. I will notify my insurance provider of the receipt of any medicines through the Pfizer Patient Assistance Program. I have a signed copy of a current and completed Authorization to Share Health Information form on record with my Prescriber so that my Prescriber may share health information about me with the Pfizer Patient Assistance Program, Pfizer, and the Pfizer Patient Assistance Foundation Inc.

SIGN X _____ _____ _____

Patient Signature* (Patient or patient representative must be 18 years or older)‡ | Patient representative name (please print)§ | **Date***

If signed by patient representative, you must indicate below the authority to act on behalf of patient¶:

☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

‡Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.

§NOT required if patient signs.

¶Required if patient representative signs.

9 PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (*REQUIRED)

By signing and dating this form, I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare 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 the program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of my insurer's prior authorization requirements
  - Assisting with identification of my insurer's requirements for appealing a denied claim
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Communicating with my Healthcare 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's products, services, and programs
- Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their 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 Healthcare Providers or payment from my health insurer. However, if I do not sign and date this form, VyndaLink 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. I consent to Pfizer using my health information 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 state law requires a shorter period, or 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 VyndaLink at PO Box 221296, Charlotte, NC 28222 or call 1-888-222-8475, Monday-Friday, 9 AM-6 PM ET. This withdrawal will not affect the use or sharing of my health information that took place before I withdrew my approval. I understand I will receive a copy of this form.

SIGN X _____ _____

Patient Signature* (Patient or patient representative must be 18 or older)† **Date***

SIGN X _____ _____

Patient representative name (please print)‡ **Date**

If signed by patient representative, you must indicate below the authority to act on behalf of patient§:

☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions

☐ Other _____

†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡NOT required if patient signs.
§Required if patient representative signs.

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FOR HEALTHCARE PROFESSIONALS – Please complete the form where applicable and return via mail or fax. All pages must be returned to VyndaLink.

IMPORTANT NOTE: Commercially insured patients are not eligible for assistance. Patients must have an FDA-approved diagnosis to be considered for the Pfizer Patient Assistance Program.†

☐ **Check here if the patient is reapplying for the Pfizer Patient Assistance Program.**

10 PRESCRIBER INFORMATION (*REQUIRED)

First Name* _____ **Last Name*** _____

Payer-Specific #* _____ **NPI #*** _____ **State License #*** _____

Practice Name* _____ **Address*** _____ **City*** _____ **State*** _____ **ZIP*** _____

Office Contact Name* _____ **Office Contact Phone*** _____ **Office Fax*** _____

Email _____ Preferred Communication Method: ☐ Phone ☐ Fax

10A REQUIREMENT BEFORE REQUESTING ASSISTANCE AND REQUEST FOR BENEFITS VERIFICATION (if needed)

The VYNDAMAX prescription must be sent to the Specialty Pharmacy Provider for a benefits verification/test claim and/or you or your patient must contact their insurer directly to obtain the patient's co-payment amount, out-of-pocket maximum, and amount met toward their out-of-pocket maximum. If you or your patient do not know which Specialty Pharmacy is in network or if there is a coverage issue that requires research, VyndaLink can conduct a benefits investigation. Check below if a benefits verification is needed.

☐ **Benefits Investigation–Specialty Pharmacy unknown** ☐ **Benefits Investigation–Payer coverage issue**

11 PRESCRIBER CERTIFICATION (*REQUIRED)

The information you provide will be used by Pfizer Inc. ("Pfizer") to improve and tailor our products and services to better serve you. The information will also be used by the Pfizer Patient Assistance Foundation™ and parties acting on their behalf to administer and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

By signing below, you, the Prescriber, understand and agree to the following: I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable. Any medications supplied by Pfizer as a result of this enrollment 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, nor will any cost related to it be applied toward the patient's true out-of-pocket costs (TrOOP). I certify that the information provided is current, complete, and accurate to the best of my knowledge. **I certify that my decision to prescribe a Pfizer product is based solely on my independent clinical judgment and I have prescribed the product for an FDA-approved indication.** I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I understand that commercially insured patients are not eligible for the Pfizer Patient Assistance Program, even if their prescription is not covered by the commercial insurance plan. Any employer-funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that the patient is a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan. If the patient has Medicare Part D, Pfizer will notify the Medicare Part D plan of their participation in the Pfizer Patient Assistance Program. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. Pfizer may contact the patient directly to confirm the receipt of medications. The information provided on this enrollment form is subject to random audits and verification. Pfizer may change or cancel this program at any time; Pfizer also reserves the right to terminate my patient's enrollment at any time. I will notify the Pfizer Patient Assistance Program immediately if the Pfizer product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes. I have a signed copy on file of my patient's current and completed Patient Authorization to Share Health Information Form so that I may share patient health information with the Pfizer Patient Assistance Program, Pfizer, and the Pfizer Patient Assistance Foundation Inc.

SIGN X _____ _____

Healthcare Provider Signature* Date*

12 SHIPPING INFORMATION (*REQUIRED)

Ship to* ☐ Patient ☐ Prescriber ☐ Other (please provide shipping address—NO PHARMACIES) _____

Address* _____ **City*** _____ **State*** _____ **ZIP*** _____

13 PATIENT INFORMATION (*REQUIRED)

Patient Full Name* _____ **Patient DOB*** _____

The product costs were obtained from the payer/pharmacy and I certify that the patient is unable to afford this.* ☐ Yes ☐ No

Insurer-required co-payment* _____ **Date*** _____ **Specialty Pharmacy Provider*** _____

Out-of-pocket (OOP) maximum for prescriptions* _____ **Amount met toward OOP max*** _____

Does the payer require a Prior Authorization?* ☐ Yes ☐ No **Prior Authorization Number‡*** _____ **Prior Authorization Dates‡*** _____

A copy of the Prior Authorization can be submitted to satisfy this requirement.

14 DIAGNOSIS (*REQUIRED)

Primary ICD-10* _____ Secondary ICD-10 _____

15 CLINICAL AND PRESCRIPTION INFORMATION NOTE: Patient must have an on-label diagnosis to be considered for the Pfizer Patient Assistance Program. (*REQUIRED)

Rx* ☐ VYNDAMAX 61 mg: One 61 mg tafamidis capsule orally once daily, Quantity #30 capsules (30 days) _____ **Refills #*** _____

Drug Allergies: ☐ Yes ☐ No If yes, please list medication(s) and associated reaction(s) _____

Patient's current medication(s) _____

SIGN X _____ _____

Prescribing Physician Signature* – NO STAMPS Date*

Note: If you are a New York prescriber, please attach state prescription form. e-Prescriptions should be sent to AmeriPharm (NPI number - 1073692745; NCPDP number - 4351968), or MedVantx under retail pharmacies (NPI number - 1235371535; NCPDP number - 4354180). If you choose to e-Prescribe directly to AmeriPharm or MedVantx, you are certifying you have received patient consent for AmeriPharm or MedVantx and VyndaLink.

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‡Required if a Prior Authorization is required by the payer.