



**Claims Department**  
 P.O. Box 845  
 Stevens Point, WI 54481  
 Toll Free 1-800-276-0726

AIG Claims, Inc. is a wholly owned subsidiary of AIG and provides claims administration for the Group Policy provided with your Pfizer Pledge™ Warranty Program.

## PFIZER PLEDGE™ WARRANTY PROGRAM HEALTHCARE PROVIDER ATTESTATION FORM

*(TO BE COMPLETED BY PANZYGA® (immune globulin intravenous, human - ifas)-PRESCRIBING HEALTHCARE PROVIDER)*

Please FAX the **completed** form to 1-715-342-2490 or mail to: Pfizer Pledge™ Warranty Program, P.O. Box 845, Stevens Point, WI 54481. For questions, please call 1-800-276-0726, Monday through Friday, 8 AM to 8 PM ET.

**For details about how Pfizer collects and uses personal information, including applicable US state privacy rights and notices for California residents, please visit [www.pfizer.com/privacy](http://www.pfizer.com/privacy).**

**Patient Information**

Patient Name (First/MI/Last): \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

**PANZYGA-Prescribing Healthcare Provider/Site of Care Information**

Prescribing Healthcare Provider Name (First/MI/Last): \_\_\_\_\_

Practice/Institution Name: \_\_\_\_\_

Address, City, State, ZIP: \_\_\_\_\_

NPI #: \_\_\_\_\_

State License #: \_\_\_\_\_

FAX # (with area code): \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact E-mail: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

**Healthcare Provider Pfizer Pledge™ Warranty Program Attestation for PANZYGA**

For which indication was PANZYGA prescribed? (check one)

- Chronic inflammatory demyelinating polyneuropathy (CIDP) in adults
- Another indication

Did the patient receive immune globulin therapy in the previous 12 months? (check one)

- Yes
- No

Did the patient discontinue PANZYGA therapy before the fifth treatment? (check one)

- Yes
- No



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Please provide a brief description for the clinical rationale for discontinuation (NOTE: scans, test results, etc are not required):

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**Healthcare Provider Consent**

I understand that completing this attestation form does not guarantee that a warranty remedy will be provided to my patient. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. I understand that the information provided on this attestation form is subject to random audits and verification. I understand that my information may be provided to Pfizer for its administration and compliance of the Pfizer Pledge™ Warranty Program. Pfizer may change or cancel this program at any time. Should Pfizer change or cancel the program, it will continue to honor valid warranty claims related to qualifying treatments of PANZYGA administered during the period in which the program remained in effect.

**Healthcare Provider HIPAA and Telephone Consumer Protection Act (TCPA) Attestation**

By my signature, I certify that the information I have provided above is true. I also 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 the Pfizer Pledge™ Warranty Program, including, assisting the patient with seeking a warranty claim for a Pfizer medicine through the Pfizer Pledge™ Warranty Program. I certify that I have obtained consent from the patient or the patient’s caregiver to be contacted by Pfizer, Pfizer Pledge™ Warranty Program, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above. I also give my permission to receive calls related to these services from Pfizer, Pfizer Pledge™ Warranty Program, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided. I consent to providing my information to Pfizer as it relates to the Pfizer Pledge™ Warranty Program.

Healthcare Provider Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_