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
PHARMACY ATTESTATION FORM

TO BE COMPLETED BY EITHER
THE PHARMACY DISPENSING PANZYGA® (immune globulin intravenous, human - ifas) OR
THE CLINIC INFUSING PANZYGA® (immune globulin intravenous, human - ifas)

Please FAX the **completed** form to 1-715-342-2490 or mail to: Pfizer Pledge Warranty Program, PO 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.

Patient Information

Patient Name (First/MI/Last): _____

Date of Birth (MM/DD/YYYY): _____

Prescribing Healthcare Provider Name (First/MI/Last): _____

PANZYGA TREATMENT					
Treatment Number		1	2	3	4
Treatment Date (MM/DD/YY)					
Prescription Number(s)					
TOTAL GRAMS Prescribed per Treatment					
NDCs (Only Pfizer NDCs Eligible)	Grams/Vial	**# OF VIALS OF EACH NDC DISPENSED FOR EACH TREATMENT**			
00069-1011-01 or 00069-1011-02	1				
00069-1109-01 or 00069-1109-02	2.5				
00069-1224-01 or 00069-1224-02	5				
00069-1312-01 or 00069-1312-02	10				
00069-1415-01 or 00069-1415-02	20				
00069-1558-01 or 00069-1558-02	30				
Total Amount Patient Paid Out-of-Pocket Enter $'s Received (or $0 if none)					
Total Amount of Financial Assistance from the Pfizer PANZYGA Co-Pay Program Enter $'s Received (or $0 if none)					
Total Amount of Co-Pay Assistance from any other Source other than the Pfizer PANZYGA Co-Pay Program) Enter $'s Received (or $0 if none)					

PANZYGA Pharmacy or Clinic Information

Are you the Pharmacy or Clinic that prepared PANZYGA for this patient? (check one) ☐YES ☐NO

Pharmacy or Clinic Name: _____

Address, City, State, ZIP: _____

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Pharmacy License # (Pharmacy only): _____

NPI # (Clinics only): _____

FAX # (with area code): _____

Contact Name: _____

Contact Email: _____

Contact Phone: _____

Pfizer Pledge™ Warranty Program Attestation for PANZYGA

I confirm that this patient was prescribed PANZYGA and: (check ALL that apply)

- ☑ Drug information provided above is only Pfizer NDC's
- ☑ The out-of-pocket amount represents the total amount paid by the patient specifically for PANZYGA

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 Pharmacies, 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.

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.

Authorized Representative Signature: _____

Date of Signature: _____