



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™
HEALTH CARE PROVIDER ATTESTATION FORM

(TO BE COMPLETED BY PANZYGA® (Immune Globulin Intravenous [Human]) PRESCRIBING HEALTH CARE PROVIDER)

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–Friday, 8 am–8 pm ET. AIG Claims, Inc. and/or its affiliates (collectively, “AIG”) has been appointed by Pfizer as its third-party administrator to determine eligibility and administer warranty claims. For details about how AIG collects and uses personal information submitted via this form, please visit <https://www.aig.com/privacy-policy>.

Patient Information

Patient Name (First/MI/Last): _____

Date of Birth (mm/dd/yyyy): _____

PANZYGA Prescribing Health Care Provider/Site of Care Information

Prescribing Health Care 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: _____

Health Care Provider Pfizer Pledge Attestation for PANZYGA

For what indication was PANZYGA prescribed? (check which applies)

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

Did the patient receive another immune globulin therapy in the previous 12 months? (check which applies)

- Yes
- No

Did the patient discontinue PANZYGA therapy before the 5th treatment? (check which applies)

- 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):

Health Care 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.

Health Care 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 regarding the purposes described above. I consent to providing my information to Pfizer as it relates to the Pfizer Pledge Warranty Program.

I declare that, to the best of my knowledge and belief, all of the information provided in support of this claim is complete, true and accurate. I understand that if I made or shall make any false or fraudulent statements or withhold material facts relating to this claim, this could result in the forfeiture of patient benefits.

Acknowledgement of State Fraud Laws

For residents of all states except those states and territories noted below:

WARNING: Any person who knowingly and with the intent to injure, defraud, deceive any insurance company or other person, who files a statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which



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may be a crime and may be subject to criminal prosecution, civil penalties and forfeiture of insurance benefits.

For residents of WASHINGTON D.C., MAINE, TENNESSEE, VIRGINIA and WASHINGTON:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

For residents of ARKANSAS, KENTUCKY, LOUISIANA, NEW MEXICO, PENNSYLVANIA, RHODE ISLAND, TEXAS and WEST VIRGINIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under this title.

ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or Card Member for the purpose of defrauding or attempting to defraud the policyholder or Card Member with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE, IDAHO and OKLAHOMA:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

INDIANA: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.



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MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Health Care Provider Signature: _____

Date of Signature: _____