Factor Savings Card - Medical Benefit Option

Please complete ALL fields with black ink and fax ALL documents to [1-844-250-7194].

Please send a copy of the Patient's Explanation of Benefits and Signed HIPAA Form.

For help, please call 1-877-329-8294. Available hours are Monday through Friday 8 AM - 5 PM (ET).

Payment Option Enrollment

Choose a payment option: ☐ Check here if applying for a Virtual Debit Card

☐ Check here if applying for reimbursement via check (Check will be sent to Financial/Billing Site location listed below.)

Financial/Billing Site Information

Contact Name:	Contact Phone Number:	
Billing Site Name:	Address:	
City:	State:	ZIP Code:
Phone Number:	Fax Number:	

Infusion Site Information

Contact Name:	Contact Phone Number:	
Infusion Site Name:	Address:	
City:	State:	ZIP Code:
Phone Number:	Fax Number:	

Patient Information

Enter Factor Savings Card Member ID Number:		☐ Copy of Explanation of Benefits Attached	
Last Name:		First Name:	MI:
Gender: ☐ Male ☐ Female	Date of Birth:	Address:	
City:		State:	ZIP Code:

Physician Information

Physician Name:	Address:	
City:	State:	ZIP Code:
Phone Number:	Fax Number:	

Please ensure that the fax and mailing information provided is correct and current. The fax number will be used to deliver the Virtual Mastercard information.

Please visit the Hemophilia Village website at www.hemophiliavillage.com and obtain the 11-digit Factor Savings Card member ID number needed on this form.

Healthcare Provider's Signature Date

By my signature, I certify that I am a physician or a healthcare provider authorized to sign on behalf of a patient and authorize the Factor Reimbursement Helpline and its agents (the "Helpline") to use any information provided on this form for the purposes of verifying coverage and benefits for Factor, or referring the patient to the Factor Savings Card Program in the event the patient does not have insurance. I certify that I have included a signed copy of this patient's authorization (in a form that complies with all applicable state and federal laws) that allows me and the patient's health insurers to use and disclose the patient's health information, including his or her medical and insurance coverage information and records, to the Helpline, the Factor Savings Card Program, and their respective agents. I understand and agree that I remain responsible for complying with all applicable federal and state laws regarding patient privacy. The authorization form signed by the patient that I have on file informs the patient that: (a) the information disclosed may include the patient's health status; (b) the patient's information may be subject to re-disclosure by the recipients and no longer protected by state or federal privacy laws; (c) I will not condition the patient's treatment, payment, enrollment in a health plan, or eligibility for benefits on the patient providing the requested authorization; (d) the patient has the right to revoke the authorization at any time by calling the Helpline at 1-877-329-8294; (e) such revocation would end the patient's eligibility to participate in the program; and (f) if the patient revokes the authorization, the revocation will prohibit disclosures after the date the written revocation is received, but will not affect previous disclosures made in reliance on the patient's authorization. The patient's signature will be maintained and available for audit purposes as required by all applicable state and federal privacy laws. To the best of my knowledge, all information contained in this form is correct and complete and consistent with applicable privacy laws and regulations, and I understand that the Helpline is relying on this representation. I further certify that I made the above prescribing decisions based on my own independent medical judgment regarding what is in the best interests of the patient.

Patient Authorization

Please complete ALL fields, with black ink and fax ALL documents to [1-844-250-7194].

Patients must read this and sign the acknowledgment below before they can participate in the Program.

My signature on the previous page of this form confirms that I allow my doctor(s), any other healthcare providers, specialty pharmacy providers, and my health plan or insurers to share medical information relating to my use or potential use of Factor® (Benefix® or Xyntha®) with Pfizer, Inc., including our affiliates and our service providers that work on their behalf, in connection with the Program (the "Companies"). The Companies administer the Factor Savings Card Program ("the Program") for Pfizer, Inc., maker of Factor.

This information can include spoken or written facts about my health and payment benefits I may have. It may include copies of records from my healthcare providers or health plans about my health or health care.

The Companies may use and share this information to help find alternate funding sources for Factor, and perform other related services. The Companies may also share my information with other related parties of this program or as otherwise set forth above. The Companies will use and share this information to see if I qualify for the Programs and to run the Programs. In addition, the Companies may use and share my information to refer me to other programs, foundations, or alternate sources of funding or coverage that may be available to provide assistance to me with costs of Factor. Program management employees of the Companies may also see my information, but they may use it only in connection with the Program, to help me get assistance with the costs of Factor, or as otherwise required or allowed under the law. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. If I change my mind, I can inform my healthcare providers and my insurers in writing that I do not want them to share any information with Pfizer Inc., including our affiliates, and our service providers, that work on their behalf in connection with the Program, but will not change any information shared before I notified them of my desire to discontinue. I know that I have a right to see or copy the information my healthcare providers or insurers have given to the Companies.

I understand that I am not required to sign this form on the previous page. My choice about whether to sign this form will not change the way my healthcare providers or insurers treat me. If I refuse to sign on the previous page of this form, I know that this means I will not be able to receive assistance from the Program.

Patient Printed Name

Patient Signature Date