CCPA Purchasing Partners
Pfizer Vaccine Participation Form

This form must be returned to CCPAPP using the fax number or email address listed below. All information must be accurate and complete to ensure timely processing. Once you have returned this form, please allow up to 30 days to become effective under the CCPAPP-Pfizer agreement and to receive the contracted discount on Trumenba®. If your practice has more than one location with a distributor ordering account, please submit a separate form for each location. Please verify participation in the agreement prior to placing your first order.

Selection of Authorized Distributor

As a preferred business partner of CCPAPP, **McKesson** has been chosen as the default distributor for all of our member practices. If you currently do not have a McKesson ordering account, please contact CCPAPP or McKesson for assistance. A McKesson new account application can also be found on the *Vendors Form Page* of the CCPAPP website. Should your practice prefer to utilize a distributor other than McKesson to purchase Pfizer's Trumenba® through CCPAPP's agreement, you may select another distributor from the listing found on the Pfizer website:

http://www.pfizer.com/products/hcp/pfizer_authorized_distributors/all

Please indicate your selected authorized distributor (only one distributor may be listed below):

Authorized Distributor:_____

(Please note: If no distributor is indicated, if more than one distributor is indicated, and/or if your practice indicates a distributor that is not found on Pfizer's authorized distributor listing, McKesson will remain as your practice site's authorized distributor).

Physician Information:

Please provide the First Name, Last Name, Title and DEA License Number of the physician at your practice site who is registered with your practice site's ordering account. Please write legibly.

Physician Name, Title: _____

DEA License Number: _____

Practice Site Information:

Practice Site Name: _____

Address, Suite: _____

City, State, Zip:_____ **Phone:** _____

Acceptance to "Own Use" Agreement Requirement and Authorizing Signature:

On behalf of my practice, I understand and agree that Trumenba® and any other product that may be purchased under the CCPAPP-Pfizer agreement is sold to Members of CCPAPP for their "own use" and no such product purchased hereunder by my practice may be commercially resold to any other entity or person.

_____

First Name, Last Name, Title of Authorized Signer (Please print)

_____

Authorizing Signature **Date**

Please email this completed form to: info@ccpapp.org or fax to: 888.276.2344