Pfizer Oncology together™

QUESTIONS? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

Patient Support Enrollment Form for Orals

☐ **Benefits Verification** – We'll determine the patient's health insurance coverage and out-of-pocket costs and fax a summary of benefits to the HCP office.

☐ **Uninsured or Government Underinsured Patient: Pfizer Patient Assistance Program (PAP)*** –
This is intended for patients who are uninsured or are government underinsured and understand co-pay requirement but cannot afford co-pay.

☐ **Care Champion Program** – Our Care Champions, who have social work experience, can offer the patient resources that may help with some of their day-to-day challenges.

Orals

☐ BOSULIF® (bosutinib)
☐ BRAFTOVI® (encorafenib)
☐ DAURISMO™ (glasdegib sodium)
☐ IBRANCE® (palbociclib)
☐ INLYTA® (axitinib)
☐ LORBRENA® (lorlatinib)
☐ MEKTOVI® (binimetinib)
☐ TALZENNA® (talazoparib)
☐ VIZIMPRO® (dacomitinib)
☐ XALKORI® (crizotinib)

Patient Eligibility for the Pfizer Patient Assistance Program

To qualify for free medicine†, the patient must meet the criteria below:

- Have a valid prescription for the Pfizer medicine for an FDA-approved indication and the physician has attested to this on the enrollment form
- Have an annual household income at or below 500% of the Federal Poverty Level
- Be 18 years of age or older
- Reside in the U.S. or a U.S. territory
- Be treated by a healthcare provider licensed in the U.S. or a U.S. territory
- Meet one of the following:
  - Have no insurance coverage
  - Have government insurance, understand co-pay requirements as a result of the completion of a Benefit Investigation/Pharmacy Claim, and are unable to afford their insurer required co-pay
  - Have been denied coverage by your government insurer for the Pfizer medicine listed above (after at least one unsuccessful appeal to your insurer)

†Eligibility criteria are subject to change at any time.

Commercially insured patients are not eligible to enroll in the Pfizer Patient Assistance Program.

Enrollment Checklist for Patients

Pages 2 through 5 should be completed by the patient or caregiver. When completing these pages, keep the following points in mind:

- **To apply for PAP:** Review the information above. Then, complete **Section 5**. (You'll also need to complete **Section 3** and either attach proof of income or complete **Section 4** to consent to Electronic Income Verification.)
  - To receive refill reminders, sign up for text message alerts from the PAP
- Opt in to the Care Champion program and sign up for text message alerts in **Section 7**
- Include copies of the front and back of your medical and pharmacy insurance cards
- Review and provide signatures on pages 3, 4, and 5

Enrollment Checklist for HCP

Pages 6 through 7 should be completed by the healthcare provider. Fill out every section for all patient enrollment requests and:

- Review patient eligibility for the Pfizer Patient Assistance Program above and complete required **Sections 8, 9, 10, and 16**.
- Read the attestation and sign the consent statement in **Section 11**
- Specify the Diagnosis in **Section 13** and complete **Section 14**
- Sign the Prescription in **Section 17**

*The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

HCP Information

*Required fields

HCP Name (First/MI/Last)*	Contact Phone*

1 Patient Information

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*	Sex* ☐Male ☐Female ☐Other
Street Address*		
City*	State*	ZIP Code*
Phone* ☐H ☐M ☐W	Email Address	
Best Time to Contact ☐Morning ☐Afternoon ☐Evening	Preferred Language (if not English)	
Caregiver Name	Caregiver Relationship	Caregiver Phone ☐H ☐M ☐W

2 Patient Insurance Information

IMPORTANT NOTE: Commercially Insured Patients are not eligible for the Pfizer Patient Assistance Program.†

Is the Pfizer medication covered by either medical or prescription insurance? ☐Yes ☐No ☐I don't know	**If yes, what is the co-pay amount? $** ☐I don't know

	Primary Insurance	**Secondary Insurance**	**Prescription Insurance**
Check Insurance Type*: ☐None (Skip to Section 3)	☐Commercial ☐Medicare ☐Medicaid ☐Other	☐Commercial ☐Medicare ☐Medicaid ☐Other	☐Commercial ☐Medicare ☐Medicaid ☐Other
Insurance Name*			
Insurer's Phone*			
Policy/Medicare Beneficiary ID #*			
Group #*			
Policyholder Name*			
Relationship to Patient			
Policyholder DOB			
BIN #*			
PCN #*			

Medicare Part D Plan Name (if applicable)

Address		
City	State	ZIP Code

Note: Include copies of the front and back of your medical and pharmacy insurance cards with your enrollment form.

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

3 Patient Financial Information Required if requesting assistance through the Pfizer Patient Assistance Program.† *Required fields

My provider or pharmacy has reviewed my insurer-required co-payment with me and I certify that I am unable to afford this. ☐ Yes ☐ No

Total Number of People Within Household (including applicant)	Total Annual Household Income $

If you choose not to opt in for Electronic Income Verification in Section 4, you must submit documentation for household to support the financial information you've listed.
Attached is: ☐ Most recent federal tax return (Page 1 of IRS 1040 form) ☐ W-2 form ☐ Other

4 Patient Authorization for Electronic Income Verification (Optional – Only if applying for the Pfizer Patient Assistance Program.†)

I, the applicant named below, understand that I am providing "written instructions" to Pfizer, Pfizer Oncology Together, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf under the Fair Credit Reporting Act authorizing the Pfizer Oncology Together to obtain information from my credit profile or other information from Experian™ Income View℠. I authorize Pfizer to obtain such information solely for the purpose of determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Pfizer Patient Assistance Program financial screening process.

I understand that I am entitled to a copy of this Authorization upon request. This Authorization shall be valid from the date of the signature on this form through the enrollment period (unless a shorter timeframe is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366, but that this cancellation will not apply to any information already used or disclosed through this Authorization.

Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements and agree to the outlined terms.

SIGN

Patient Signature* (Patient or patient representative)	Patient representative name (please print)	**Date***

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

5 Pfizer Patient Assistance Program† Certification, Attestation, and Privacy Disclosures

By signing the form, I certify that I have been prescribed the requested medicine for an FDA-approved diagnosis and I cannot afford my medication. I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. I will promptly contact the Pfizer Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription drugs. I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans. I will notify my insurance provider of the receipt of any medicines through the Pfizer Patient Assistance Program. I have a signed copy of a current and completed Patient Authorization to Share Health Information on record with my HCP so that my HCP may share health information about me with Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation, Inc.

The information you provide will be used by Pfizer, Pfizer Oncology Together, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve Pfizer's assistance programs, to communicate with you about your experience with Pfizer's assistance programs, to help you understand your insurance coverage and help you access certain Pfizer medicines through your insurance, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

I understand that: completing this enrollment form does not guarantee that I will qualify for Pfizer's assistance programs. Pfizer may contact my insurer to help me understand my insurance coverage for certain products and may provide me with support to obtain coverage through my insurer, including prior authorization and appeals assistance (if necessary and available). Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by Pfizer's assistance programs shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel Pfizer's assistance programs, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Pfizer Patient Assistance Program, Pfizer will notify my Part D Plan of my enrollment in the Pfizer Patient Assistance Program. If I am a new commercially insured patient applying after January 1, 2023, I cannot receive assistance through the Pfizer Patient Assistance Program.

Permission for Refill Reminder text communications:

☐ Text me about my refills! By checking this box, I consent to receive refill reminders and shipping texts if I am accepted into the Pfizer Patient Assistance Program. I will receive a welcome text asking me to reply CONFIRM to opt in. Messages and data rates may apply. Number of messages varies based on program use, but is up to 5 texts per month. Reply STOP to cancel. Privacy policy and full Terms available here: www.pfizer.com/privacy. Please enter the number you would like to enroll for texting (_____) _____ - _____.

SIGN

Patient Signature* (Patient or patient representative)	Patient representative name (please print)	**Date***

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

6 Patient Consent to Receive Communications ✓ This is required for all services. *Required fields

By signing this form, I agree to receive communications from Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer, Pfizer Oncology Together, or parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number(s) provided. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer Oncology Together at 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

SIGN

Patient Signature* (Patient or patient representative)	Patient representative name (please print)	**Date***

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

7 Personalized Patient Support Programs Opt-In (Optional)

Care Champions

Personalized patient support is offered through Pfizer Oncology Together via Care Champions. You can speak with a Care Champion for resources that may help with your daily life. Your Care Champion may provide information about your condition, Pfizer Oncology medicine, or topics such as nutrition, as well as a co-pay card offer for eligible patients. Your Care Champion can also connect you to independent organizations that provide services such as transportation and lodging for your treatment-related appointments. These offerings may vary based on your prescribed medicine. To opt in to this program, please check the box below.

☐ By checking this box, I request Care Champion support and agree to communications from Pfizer Oncology Together, Pfizer, and/or parties acting on their behalf. These communications may include calls to my phone number made with an autodialer or prerecorded voice about resources and other support such as those described above. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services. I understand that I can opt out of these communications at any time by contacting Pfizer Oncology Together at 1-877-744-5675.

Permission for text communications:

You can receive communications from the Care Champion program via text message.

☐ By checking this box, I consent to receive autodialed marketing and other texts from Pfizer and its service providers regarding the Pfizer Oncology Together Care Champion program at my mobile phone number, (_____) _____ - _____. I understand that providing consent is not required or a condition of purchasing any products or services. Message and data rates may apply. Approximately 8 messages per month. Complete terms can be found at http://3csms.mobi/pfizer2/ and Pfizer's privacy policy at Pfizer.com/privacy. Reply STOP to opt out.

SIGN

Patient Signature* (Patient or patient representative)	Patient representative name (please print)	**Date***

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

Pfizer Oncology together™

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

- **To Patient: Read, sign, and date the Patient Authorization form. This is required to request assistance.**
- **To HCP: Send to Pfizer Oncology Together. Fax to: 1-877-736-6506 or Mail to: Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366**

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Pfizer Inc., the Pfizer Patient Assistance Foundation, Pfizer affiliates and its vendors (collectively, "Pfizer"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Pfizer so that Pfizer may provide me with various support and information to help me access a Pfizer medicine, which may include the following, depending on your program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of prior authorization requirements
  - Assisting with identification of requirements of your insurer for appeal of a denied claim
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Sending me a device and starter kit (where appropriate)
- Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities
- Providing me with financial assistance resources and information if I'm eligible
- Providing me with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve our operations and services.

I understand that I do not have to sign this form, and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, the Pfizer Oncology Together may not be able to provide me with assistance.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Pfizer agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me.

I understand that this form will remain in effect for 4 years from the date of my signature unless I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact the Pfizer Oncology Together at P.O. Box 220366, Charlotte, NC 28222-0366 and call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

I also give my permission to receive communications from Pfizer, the Pfizer Oncology Together, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt-out of these communications at any time by contacting Pfizer Oncology Together at 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

SIGN **Patient Signature** (Patient or patient representative)

Patient representative name (please print)	Date

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

QUESTIONS? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

8 Patient Information

*Required fields

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*
Is your patient's Pfizer medication covered by either medical or prescription insurance? ☐Yes ☐No ☐I don't know **IMPORTANT NOTE:** If the patient is commercially insured, they are not eligible for assistance through the Pfizer Patient Assistance Program.	If yes, what is their co-pay amount? $ ☐I don't know
Has your office or a pharmacy completed a Benefit Investigation/Pharmacy Claim for the requested product? ☐Yes ☐No	Does your patient understand their insured required co-pay and have they directly communicated that they are unable to afford this? ☐Yes ☐No

9 HCP/Site of Care Information

HCP Name (First/MI/Last)*			Professional Designation
Practice/Institution Name*	Address*		
City*		State*	ZIP Code*
NPI*	Group Tax ID*	State License*	DEA
Fax*	Email		

Site of Care Location*: ☐Provider's office ☐Hospital outpatient ☐Hospital inpatient ☐Other ☐N/A

Contact Name*	Contact Phone*

10 Shipping Information for Pfizer Patient Assistance Program† Patients

Required if requesting assistance through the Pfizer Patient Assistance Program.†

Patient Name*

Ship To*: ☐Patient Address (Section 1) ☐HCP/Site of Care Address (Section 9) ☐Other Address (Fill out the required information below.)

Address*		
City*	State*	ZIP Code*
Office Name*	Contact Phone*	

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

This is required for all services.

I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. Any medications supplied by Pfizer as a result of this enrollment form are for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. The information provided on this enrollment form is subject to random audits and verification. Pfizer may change or cancel this program at any time; Pfizer also reserves the right to terminate my patient's enrollment at any time.

By my signature, I 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 Pfizer's patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for Pfizer Oncology medication.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, Pfizer Oncology Together, and parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Pfizer, Pfizer Oncology Together, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

SIGN

HCP Signature* _____ **Date*** _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

QUESTIONS? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

12 Patient Information

*Required fields

Patient Name (First/MI/Last)*

Patient DOB (mm/dd/yyyy)*

13 Diagnosis

Primary Diagnosis ICD-10*

Secondary Diagnosis ICD-10

14 Prescription Information for Orals ✓ Required.

Please check the medicine prescribed and indicate strength & quantity.* Please provide complete directions and dosing information below.

- ☐ BOSULIF (bosutinib) _____ mg, 30-day supply
- ☐ BRAFTOVI (encorafenib) ☐ 300 mg, ☐ 450 mg, ☐ Other: _____ ☐ 30-day supply, ☐ Other: _____
- ☐ DAURISMO (glasdegib sodium) _____ mg, 30-day supply
- ☐ IBRANCE (palbociclib) _____ mg, 28-day supply
- ☐ INLYTA (axitinib) _____ mg, 30-day supply
- ☐ LORBRENA (lorlatinib) _____ mg, 30-day supply
- ☐ MEKTOVI (binimetinib) ☐ 45 mg, ☐ Other: _____ ☐ 30-day supply, ☐ Other: _____
- ☐ TALZENNA (talazoparib) _____ mg, 30-day supply
- ☐ VIZIMPRO (dacomitinib) _____ mg, 30-day supply
- ☐ XALKORI (crizotinib) _____ mg, 30-day supply

Directions/Dosing Instructions*:

Indicate number of refills*:

Drug Allergies* ☐ Yes ☐ No (If yes, please list medication[s] and associated reaction[s]):

Concomitant Medications*:

Other Known Conditions*:

15 Preferred Specialty Pharmacy

Preferred Specialty Pharmacy Name*

☐ Self-Dispensing Pharmacy

Preferred Specialty Pharmacy Address*

The patient identified above prefers use of the Specialty Pharmacy indicated above. I authorize Pfizer and its affiliates, agents, representatives, and service providers to fax this prescription to the Specialty Pharmacy designated above, provided it is approved by this patient's plan. If the Specialty Pharmacy designated is not a plan-approved Specialty Pharmacy, then to a Specialty Pharmacy approved by this patient's plan. If there is no preferred Specialty Pharmacy indicated, then to any Specialty Pharmacy approved by this patient's plan.

16 Pfizer Patient Assistance Program† Healthcare Provider Consent ✓ Required if requesting assistance through the Pfizer Patient Assistance Program.†

I, a licensed healthcare provider, certify that the product(s) I have prescribed to the patient on this Enrollment Form based on my independent medical judgment are for an FDA-approved indication. I understand that my patient must have an FDA-approved indication to be considered for enrollment in the Pfizer Patient Assistance Program and, if this certification is not signed and dated, my patient will be denied assistance.

SIGN

HCP Signature*

Date*

17 Prescription Signature

I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I authorize Pfizer, and its affiliates, agents, representatives and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

SIGN

HCP Signature* (Dispense As Written)

HCP Signature* (Substitution Allowed)

Date*

Please Note: If you wish to e-prescribe and you cannot find AmeriPharm (NPI number–1073692745; NCPDP number–4351968), please search for MedVantx under retail pharmacies (NPI number–1235371535; NCPDP number–4354180). The prescription will be sent to the same place. **New York prescribers must e-prescribe.**

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

SUBMIT FORMS AND DOCUMENTS VIA **PfizerOncologyPortal.com. Enter code: 8777366506**

FAX COMPLETED FORMS TO **1-877-736-6506**

MAIL TO Pfizer Oncology Together, **PO Box 220366, Charlotte, NC 28222-0366**

Pfizer Oncology together™

QUESTIONS? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.
JUST LOOKING FOR CO-PAY ASSISTANCE? Visit PfizerCopay.com

Patient Support Enrollment Form for Injectables

- ☐ **Co-pay Savings Program for Injectables** – Visit PfizerCopay.com to apply for the Co-Pay Program online.
- ☐ **Benefits Verification** – We'll determine the patient's health insurance coverage and out-of-pocket costs and fax a summary of benefits to the HCP office.
- ☐ **Uninsured or Government Underinsured Patient: Pfizer Patient Assistance Program (PAP)*** –
  This is intended for patients who are uninsured or are government underinsured and understand co-pay requirement but cannot afford co-pay.
- ☐ **Patient Access Navigator, for ELREXFIO™ (elranatamab) only**
  Patient Access Navigators work one-on-one with patients and their care team to provide access and reimbursement support and coordinate treatment logistics.
- ☐ **Care Champion Program** – Our Care Champions, who have social work experience, can offer the patient resources that may help with some of their day-to-day challenges.

Injectables

- ☐ BESPONSA® (inotuzumab ozogamicin)
- ☐ ELREXFIO™ (elranatamab)
- ☐ MYLOTARG™ (gemtuzumab ozogamicin)
- ☐ RETACRIT® (epoetin alfa-epbx)

Reimbursement Support and Co-pay Only

- ☐ NIVESTYM® (filgrastim-aafi)
- ☐ NYVEPRIA™ (pegfilgrastim-apgf)
- ☐ RUXIENCE® (rituximab-pvvr)
- ☐ TRAZIMERA® (trastuzumab-qyyp)
- ☐ ZIRABEV® (bevacizumab-bvzr)

- **For RUXIENCE and ZIRABEV, the Prescribing Information does not include all of the indications of the original manufacturer's product. Please see Section 14 (Page 7) to confirm and acknowledge program limitations.**
- **For ELREXFIO: Healthcare Providers, Site of Care and/or Specialty Pharmacy must be Risk Evaluation and Mitigation Strategy (REMS)-certified prior to ordering and/or dispensing medication.**

Patient Eligibility for the Pfizer Patient Assistance Program

To qualify for free medicine†, the patient must meet the criteria below:

- Have a valid prescription for the Pfizer medicine for an FDA-approved indication and the physician has attested to this on the enrollment form
- Have an annual household income at or below 500% of the Federal Poverty Level
- Be 18 years of age or older
- Reside in the U.S. or a U.S. territory
- Be treated by a healthcare provider licensed in the U.S. or a U.S. territory
- Meet one of the following:
  - Have no insurance coverage
  - Have government insurance, understand co-pay requirements as a result of the completion of a Benefit Investigation/Pharmacy Claim, and are unable to afford their insurer required co-pay
  - Have been denied coverage by your government insurer for the Pfizer medicine listed above (after at least one unsuccessful appeal to your insurer)

†Eligibility criteria are subject to change at any time.

Commercially insured patients are not eligible to enroll in the Pfizer Patient Assistance Program.

Enrollment Checklist for Patients

Pages 2 through 5 should be completed by the patient or caregiver. When completing these pages, keep the following points in mind:

- ✔ To apply for the PAP: Review the information above. Then, complete **Section 5**. (You'll also need to complete **Section 3** and either attach proof of income or complete **Section 4** to consent to Electronic Income Verification.)
- ✔ Opt in and sign up for text message alerts from the Pfizer Patient Access Navigator and/or Care Champion Program in **Section 7**
- ✔ Include copies of the front and back of your medical and pharmacy insurance cards
- ✔ Review and provide signatures on pages 3, 4, and 5

Enrollment Checklist for HCP

Pages 6 through 8 should be completed by the healthcare provider. Fill out every section for all patient enrollment requests and:

- ✔ Review patient eligibility for the Pfizer Patient Assistance Program above and complete the required **Sections 9 through 12**
- ✔ Read the attestation and sign the consent statement in **Section 17**
- ✔ Specify Diagnosis in **Section 14**. For RUXIENCE or ZIRABEV: Check the box and sign
- ✔ Sign the Prescription in **Section 21**

*The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

SUBMIT FORMS AND DOCUMENTS VIA PfizerOncologyPortal.com. Enter code: 8777366506

FAX COMPLETED FORMS TO **1-877-736-6506**

MAIL TO Pfizer Oncology Together, **PO Box 220366, Charlotte, NC 28222-0366**

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

HCP Information

*Required fields

HCP Name (First/MI/Last)*	Contact Phone*

1 Patient Information

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*	Sex* ☐Male ☐Female ☐Other
Street Address*		
City*	State*	ZIP Code*
Phone* ☐H ☐M ☐W	Email Address	
Best Time to Contact ☐Morning ☐Afternoon ☐Evening	Preferred Language (if not English)	
Caregiver Name	Caregiver Relationship	Caregiver Phone ☐H ☐M ☐W

2 Patient Insurance Information

IMPORTANT NOTE: Commercially Insured Patients are not eligible for the Pfizer Patient Assistance Program.†

Is the Pfizer medication covered by either medical or prescription insurance? ☐Yes ☐No ☐I don't know	**If yes, what is the co-pay amount? $** ☐I don't know

	Primary Insurance	**Secondary Insurance**	**Prescription Insurance**
Check Insurance Type*: ☐None (Skip to Section 3)	☐Commercial ☐Medicare ☐Medicaid ☐Other	☐Commercial ☐Medicare ☐Medicaid ☐Other	☐Commercial ☐Medicare ☐Medicaid ☐Other
Insurance Name*			
Insurer's Phone*			
Policy/Medicare Beneficiary ID #*			
Group #*			
Policyholder Name*			
Relationship to Patient			
Policyholder DOB			
BIN #*			
PCN #*			

Medicare Part D Plan Name (if applicable)

Address		
City	State	ZIP Code

Note: Include copies of the front and back of your medical and pharmacy insurance cards with your enrollment form.

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

3 Patient Financial Information Required if requesting assistance through the Pfizer Patient Assistance Program.† *Required fields

My provider or pharmacy has reviewed my insurer-required co-payment with me and I certify that I am unable to afford this. ☐Yes ☐No

Total Number of People Within Household (including applicant)	Total Annual Household Income $

If you choose not to opt in for Electronic Income Verification in Section 4, you must submit documentation for household to support the financial information you've listed.
Attached is: ☐Most recent federal tax return (Page 1 of IRS 1040 form) ☐ W-2 form ☐Other

4 Patient Authorization for Electronic Income Verification (Optional – Only if applying for the Pfizer Patient Assistance Program.†)

I, the applicant named below, understand that I am providing "written instructions" to Pfizer, Pfizer Oncology Together, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf under the Fair Credit Reporting Act authorizing the Pfizer Oncology Together to obtain information from my credit profile or other information from Experian™ Income View℠. I authorize Pfizer to obtain such information solely for the purpose of determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Pfizer Patient Assistance Program financial screening process.
I understand that I am entitled to a copy of this Authorization upon request. This Authorization shall be valid from the date of the signature on this form through the enrollment period (unless a shorter timeframe is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366, but that this cancellation will not apply to any information already used or disclosed through this Authorization.
Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements and agree to the outlined terms.

SIGN

Patient Signature* (Patient or patient representative)	Patient representative name (please print)	**Date***

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐Court Appointed ☐Guardian ☐Power of Attorney, including authority to make healthcare decisions ☐Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

5 Pfizer Patient Assistance Program† Certification, Attestation, and Privacy Disclosures

By signing the form, I certify that I have been prescribed the requested medicine for an FDA-approved diagnosis and I cannot afford my medication. I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. I will promptly contact the Pfizer Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription drugs. I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans. I will notify my insurance provider of the receipt of any medicines through the Pfizer Patient Assistance Program. I have a signed copy of a current and completed Patient Authorization to Share Health Information on record with my HCP so that my HCP may share health information about me with Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation, Inc.
The information you provide will be used by Pfizer, Pfizer Oncology Together, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve Pfizer's assistance programs, to communicate with you about your experience with Pfizer's assistance programs, to help you understand your insurance coverage and help you access certain Pfizer medicines through your insurance, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

I understand that: completing this enrollment form does not guarantee that I will qualify for Pfizer's assistance programs. Pfizer may contact my insurer to help me understand my insurance coverage for certain products and may provide me with support to obtain coverage through my insurer, including prior authorization and appeals assistance (if necessary and available). Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by Pfizer's assistance programs shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel Pfizer's assistance programs, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Pfizer Patient Assistance Program, Pfizer will notify my Part D Plan of my enrollment in the Pfizer Patient Assistance Program. If I am a new commercially insured patient applying after January 1, 2023, I cannot receive assistance through the Pfizer Patient Assistance Program.

SIGN

Patient Signature* (Patient or patient representative)	Patient representative name (please print)	**Date***

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐Court Appointed ☐Guardian ☐Power of Attorney, including authority to make healthcare decisions ☐Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.**

6 Patient Consent to Receive Communications This is required for all services. *Required fields

By signing this form, I agree to receive communications from Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer, Pfizer Oncology Together, or parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number(s) provided. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer Oncology Together at 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

SIGN

Patient Signature* (Patient or patient representative) | Patient representative name (please print) | **Date***

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

7 Personalized Patient Support Programs Opt-In (Optional)

Patient Access Navigator (For ELREXFIO Only)

When you enroll in Pfizer Oncology Together, you have the option to be contacted by a Pfizer Patient Access Navigator who can help you understand your insurance benefits and navigate the process to access your prescribed medication. Pfizer Patient Access Navigators are field-based employees of Pfizer Oncology and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. Pfizer Patient Access Navigators are very familiar with access and reimbursement requirements for ELREXFIO™ (elranatamab), and the Pfizer Patient Access Navigator assigned to you will coordinate with Pfizer Oncology Together and you on your journey to starting therapy (although you will still need to contact Pfizer Oncology Together directly if you are seeking financial assistance). Working with a Pfizer Patient Access Navigator is optional. Even if you choose not to opt in for this support, you may still access all Patient Support Activities you are eligible for by working with a case manager at Pfizer Oncology Together.

☐ By checking this box, I request Pfizer Patient Access Navigator support and agree to receive telephonic communications from the Pfizer Patient Access Navigator assigned to my case as described above. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services. I understand that I can opt out of support from and communications with the Pfizer Patient Access Navigator at any time by contacting Pfizer Oncology Together at 1-877-744-5675.

Permission for text communications:

You can receive communications from the Patient Access Navigator program via text message.

☐ By checking this box, I consent to receive autodialed marketing and other texts from Pfizer and its service providers regarding the Pfizer Oncology Together Patient Access Navigator program at my mobile phone number, (_____) _____ - _____. I understand that providing consent is not required or a condition of purchasing any products or services. Message and data rates may apply. Approximately 8 messages per month. Complete terms can be found at http://3csms.mobi/pfizer2/ and Pfizer's privacy policy at Pfizer.com/privacy. Reply STOP to opt out.

Care Champions

Personalized patient support is offered through Pfizer Oncology Together via Care Champions. You can speak with a Care Champion for resources that may help with your daily life. Your Care Champion may provide information about your condition, Pfizer Oncology medicine, or topics such as nutrition, as well as a co-pay card offer for eligible patients. Your Care Champion can also connect you to independent organizations that provide services such as transportation and lodging for your treatment-related appointments. These offerings may vary based on your prescribed medicine. To opt in to this program, please check the box below.

☐ By checking this box, I request Care Champion support and agree to communications from Pfizer Oncology Together, Pfizer, and/or parties acting on their behalf. These communications may include calls to my phone number made with an autodialer or prerecorded voice about resources and other support such as those described above. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services. I understand that I can opt out of these communications at any time by contacting Pfizer Oncology Together at 1-877-744-5675.

Permission for text communications:

You can receive communications from the Care Champion program via text message.

☐ By checking this box, I consent to receive autodialed marketing and other texts from Pfizer and its service providers regarding the Pfizer Oncology Together Care Champion program at my mobile phone number, (_____) _____ - _____. I understand that providing consent is not required or a condition of purchasing any products or services. Message and data rates may apply. Approximately 8 messages per month. Complete terms can be found at http://3csms.mobi/pfizer2/ and Pfizer's privacy policy at Pfizer.com/privacy. Reply STOP to opt out.

8 Pfizer Oncology Together Co-Pay Savings Program for Injectables

STOP **Go to pfizercopay.com and select "Patient" if you are ONLY requesting enrollment in the Pfizer Oncology Together Co-Pay Savings Program for Injectables for the following products or check the appropriate boxes below: ELREXFIO, NIVESTYM, NYVEPRIA, RUXIENCE, TRAZIMERA, and ZIRABEV.**

☐ Yes ☐ No I authorize the Pfizer Oncology Together Co-Pay Savings Program for Injectables ("Program") to provide payment directly to my healthcare provider, and not to me, for my out-of-pocket drug costs when my healthcare provider submits the co-pay claim. I authorize my healthcare provider to contact the Program on my behalf to initiate payment for services after they have been rendered. I understand that I will be responsible for any out-of-pocket expenses for my Pfizer Oncology medicine if (1) my healthcare provider does not request payment within 180 days of the issue date on my Explanation of Benefits (EOB), or (2) if I am deemed ineligible for reimbursement from the Program.

☐ Yes ☐ No I attest that I am not enrolled in a state or federally funded insurance program, including but not limited to, Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud"). I attest that I do not receive health insurance through the military.

☐ By checking this box, I confirm that I am eligible to participate in this program and agree to the Terms and Conditions specified here. Please agree to the Terms and Conditions before proceeding.

If you have questions relating to your eligibility for the Pfizer Oncology Together Co-Pay Savings Program for Injectables, you can contact Pfizer Oncology Together and provide your commercial insurance information to verify eligibility. Terms and Conditions apply. For full Terms and Conditions for injectable products, please see PfizerCopay.com/TC. Pfizer understands that your personal and health information is private and will only use your information in accordance with our Privacy Policy. The information you provide will only be used by Pfizer and parties acting on its behalf to send you the materials you requested as well as other helpful product and/or related product information, disease state information, offers, and services.

Pfizer Oncology together™

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

- **To Patient: Read, sign, and date the Patient Authorization form. This is required to request assistance.**
- **To HCP: Send to Pfizer Oncology Together. Fax to: 1-877-736-6506 or Mail to: Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366**

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Pfizer Inc., the Pfizer Patient Assistance Foundation, Pfizer affiliates and its vendors (collectively, "Pfizer"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Pfizer so that Pfizer may provide me with various support and information to help me access a Pfizer medicine, which may include the following, depending on your program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of prior authorization requirements
  - Assisting with identification of requirements of your insurer for appeal of a denied claim
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Sending me a device and starter kit (where appropriate)
- Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities
- Providing me with financial assistance resources and information if I'm eligible
- Providing me with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve our operations and services.

I understand that I do not have to sign this form, and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, the Pfizer Oncology Together may not be able to provide me with assistance.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Pfizer agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me.

I understand that this form will remain in effect for 4 years from the date of my signature unless I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact the Pfizer Oncology Together at P.O. Box 220366, Charlotte, NC 28222-0366 and call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

I also give my permission to receive communications from Pfizer, the Pfizer Oncology Together, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Oncology Together, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt-out of these communications at any time by contacting Pfizer Oncology Together at 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

SIGN **Patient Signature** (Patient or patient representative)

Patient representative name (please print)	Date

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

9 Patient Information

*Required fields

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*
Is your patient's Pfizer medication covered by either medical or prescription insurance? ☐Yes ☐No ☐I don't know **IMPORTANT NOTE:** If the patient is commercially insured, they are not eligible for assistance through the Pfizer Patient Assistance Program.	If yes, what is their co-pay amount? $ ☐I don't know
Has your office or a pharmacy completed a Benefit Investigation/Pharmacy Claim for the requested product? ☐Yes ☐No	Does your patient understand their insured required co-pay and have they directly communicated that they are unable to afford this? ☐Yes ☐No

10 HCP/Site of Care Information

HCP Name (First/MI/Last)*			Professional Designation
Practice/Institution Name*		Address*	
City*		State*	ZIP Code*
NPI*	Group Tax ID*	State License*	DEA
Fax*	Email		

Site of Care Location*: ☐Provider's office ☐Hospital outpatient ☐Hospital inpatient ☐Other ☐N/A

Contact Name*	Contact Phone*

11 Shipping Information for Pfizer Patient Assistance Program† Patients

Required if requesting assistance through the Pfizer Patient Assistance Program.†

Patient Name*

Ship To*: ☐Patient Address (Section 1) ☐Administering Provider Address (Section 15)
☐HCP/Site of Care Address (Section 10) ☐Other Address (Fill out the required information below.)

Address*

City*	State*	ZIP Code*
Office Name*	Contact Phone*	

12 Pfizer Patient Assistance Program† Healthcare Provider Consent

Required if requesting assistance through the Pfizer Patient Assistance Program.†

I, a licensed healthcare provider, certify that the product(s) I have prescribed to the patient on this Enrollment Form based on my independent medical judgment are for an FDA-approved indication. I understand that my patient must have an FDA-approved indication to be considered for enrollment in the Pfizer Patient Assistance Program and, if this certification is not signed and dated, my patient will be denied assistance.

SIGN

HCP Signature* **Date***

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

13 Patient Information *Required fields

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*

14 Diagnosis

Primary Diagnosis ICD-10*	Secondary Diagnosis ICD-10

The Prescribing Information for RUXIENCE does not include pemphigus vulgaris. Support is not available for patients prescribed RUXIENCE to treat this condition.

☐ **Please check and sign here to confirm the patient does not have this condition:** _____

The Prescribing Information for ZIRABEV does not include hepatocellular carcinoma. Support is not available for patients prescribed ZIRABEV to treat this condition.

☐ **Please check and sign here to confirm the patient does not have this condition:** _____

15 Administering Provider Information (Administering/Overseeing Product Infusion) ☐ Check if same as Section 10

Name (First/MI/Last)*			Specialty*
NPI*	Group Tax ID*	State License*	DEA
Practice Name*		Office Contact*	
Address*			
City*		State*	ZIP Code*
Phone*	Fax*	Email*	

16 Billing Address for Co-Pay Payment from the Pfizer Oncology Together Co-Pay Savings Program for Injectables

(If different from the HCP/Site of Care Information on page 5 or Administering Provider Information above.)

Practice Billing Office Name*	Practice Billing Office Contact*
Practice Billing Office Address*	
City*	State* ZIP Code*
Practice Billing Phone*	Fax* Email*

17 Healthcare Provider Consent and HIPAA and Telephone Consumer Protection Act (TCPA) Attestation ✓ This is required for all services.

I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. Any medications supplied by Pfizer as a result of this enrollment form are for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. The information provided on this enrollment form is subject to random audits and verification. Pfizer may change or cancel this program at any time; Pfizer also reserves the right to terminate my patient's enrollment at any time.

By my signature, I 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 Pfizer's patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for Pfizer Oncology medication.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, Pfizer Oncology Together, and parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Pfizer, Pfizer Oncology Together, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

SIGN

HCP Signature* _____ **Date*** _____

If you prefer to sign electronically, enter your email address here and we will send you an email with the link to complete this:

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. **For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit** www.pfizer.com/privacy.

18 Patient Information

*Required fields

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*

Drug Allergies* ☐ No ☐ Yes (If yes, please list medication[s] and associated reaction[s]):

Concomitant Medications*:

Other Known Conditions*:

19 Prescription Information for Injectables*

Required if prescribing Provider-administered injectable products and if requesting assistance through the Pfizer Patient Assistance Program.†

DRUG NAME	VIAL SIZE	# OF VIALS	REFILLS	TREATMENT START DATE	FREQUENCY OF TREATMENT	DIRECTIONS
☐ BESPONSA (inotuzumab ozogamicin)						
☐ ELREXFIO (elranatamab) Single-Dose Vial (40 mg/mL) Healthcare Providers, Site of Care and/or Specialty Pharmacy must be Risk Evaluation and Mitigation Strategy (REMS)-certified prior to ordering and/or dispensing medication	☐ 76 mg/1.9 mL ☐ 44 mg/1.1 mL					
☐ MYLOTARG (gemtuzumab ozogamicin)						
☐ RETACRIT (epoetin alfa-epbx) Single-Dose Vial (1 mL)	☐ 3000 U/mL ☐ 4000 U/mL ☐ 10,000 U/mL ☐ 40,000 U/mL					

20 Prescription Information for Injectables (Reimbursement Support and Co-Pay Only)

☐ NIVESTYM (filgrastim-aafi) Single-Dose Vial	☐ 300 mcg/mL	☐ 480 mcg/1.6 mL
☐ NIVESTYM (filgrastim-aafi) Prefilled Syringe	☐ 300 mcg/mL	☐ 480 mcg/0.8 mL
☐ NYVEPRIA (pegfilgrastim-apgf) Prefilled Syringe	☐ 6 mg/0.6 mL	
☐ RUXIENCE (rituximab-pvvr) Single-Dose Vial	☐ 100 mg/10 mL	☐ 500 mg/50 mL
☐ TRAZIMERA (trastuzumab-qyyp) Multi-Dose Vial	☐ 150 mg/vial	☐ 420 mg/vial
☐ ZIRABEV (bevacizumab-bvzr) Single-Dose Vial	☐ 100 mg/4 mL	☐ 400 mg/16 mL

21 Prescription Signature

Required if requesting assistance through the Pfizer Patient Assistance Program† or transferring the prescription to a pharmacy (as needed).

I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I authorize Pfizer, and its affiliates, agents, representatives and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

SIGN

HCP Signature* (Dispense As Written)	HCP Signature* (Substitution Allowed)	Date*

Please Note: If you wish to e-prescribe and you cannot find AmeriPharm (NPI number–1073692745; NCPDP number–4351968), please search for MedVantx under retail pharmacies (NPI number–1235371535; NCPDP number–4354180). The prescription will be sent to the same place. **New York prescribers must e-prescribe.**

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

SUBMIT FORMS AND DOCUMENTS VIA PfizerOncologyPortal.com. Enter code: 8777366506

FAX COMPLETED FORMS TO **1-877-736-6506**

MAIL TO Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366

