## **PFIZER PATIENT ASSISTANCE PROGRAM\***

prizer dermatology patient ∂ccess™

TELEPHONE: 1-844-496-8707 FAX: 1-877-548-1734 ADDRESS: 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

PATIENT APPLICATION

Please complete the form where applicable and return via mail or fax. All pages must be returned to Pfizer Dermatology Patient Access™

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 \_

Prescription Drug Insurer: Policy ID #: Rx BIN #: Policy Holder First Name: Policy Holder DOB: Policy Holder First Name: Policy Holder First Name: Policy Holder First Name: Policy Holder First Name: Policy Holder Relationship to Patient: Policy Holder Part D Insurance Mailing Address: City:  Total Number of People Within Household (including applicant): Total Annual Income for Entire Household: \$  (Annual household income may include current salary, Social Security, unemployment insurance benefits, workers compensation, and income from other sources.) If you do not want your income to be verified electronically, please submit the required documentation outlined below. Attached is:   Most recent Federal tax return (1040 form)   W-2 form   Other We must receive proof of income to determine eligibility for assistance. If you are required to file a federal tax return, please provide a signed copy. Proof of income may include documents such as: copy of most recent federal tax return, W-2 form(s), 1099 form, Social Security Award Letter or Check, or copies of three most recent pay stubs.  Patient Authorization for Electronic Income Verification (Optional, but may reduce application review time) or the Fair Credit Reporting Act authorizing Pizer Inc. to obtain information from Experian® Income View.® I. authorize Pizer Inc. to obtain information from Experian® Income View.® I. authorize Pizer Inc. to obtain information from Experian® Income View.® I. authorize Pizer Inc. to obtain information in a timely manner, if so requested. I understand that I may caldifications or the Pizer Patient Assistance Program. I also agree to provide additional financial sorcening My signature certifies that I have read an understand that above statements, and agree to the outlined terms.	☐ Check here	if reapplying for the Pfizer Pat		ce Program.					
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Total Number of People Within Household (including applicant):  Total Annual Income for Entire Household: \$  (Annual household income may include current salary, Social Security, unemployment insurance benefits, workers compensation, and income from other sources.)  If you do not want your income to be verified electronically, please submit the required documentation outlined below.  Attached is:   Most recent federal tax return (10-40 form)   W-2 form   Other    We must receive proof of income to determine eligibility for assistance. If you are required to file a federal tax return, please provide a signed copy, Proof of income may include documents such as: copy of most recent federal tax return, W-2 formis), 1099 form, Social Security Award Letter or Check, or copies of three most recent pay stubs.  Patient Authorization for Electronic Income Verification (Optional, but may reduce application review time)  the applicant named above, understand that I am providing "written instructions" to Pitzer or the Friedrich Assistance Program. I also agree to provide additional financial or the Pitzer Patient Assistance Program. I also agree to provide additional financial greate to the process of the program. I also agree to provide additional financial socientified in a timely maniner, if so requested. I understand that I am entitled to a sastence Program financial screening process. I understand that I am entitled to a work of the program financial screening process. I understand that I am entitled to a work of the program financial screening indicate below the authority to act on behalf of patient:  If signed by patient representative, please indicate below the authority to act on behalf of patient:  If signed by patient representative, please indicate below the authority to act on behalf of patient:  The information you provide will be used by Pitzer Inc. ("Pitzer"), the Pitzer Patient Assistance Program, to communicate with you about your experience with the Pitzer Patient Assistance Program, to communicate with y		Medicare Part D Insurance Mailing Addres	ss:						
PATIENT FINANCIAL INFORMATION  If you do not want your income to be verified electronically, please submit the required documentation outlined below.  Attached is:		City:			State:		ZIP:		
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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	I, the applicant named a lnc. under the Fair Cre my credit profile or oth to obtain such informa for the Pfizer Patient documentation in a tin agree to the terms in ti	above, understand that I am providing "written ins dit Reporting Act authorizing Pfizer Inc. to obtain er information from Experian® Income View. I a lation solely for the purpose of determining finar Assistance Program. I also agree to provide anely manner, if so requested. I understand that I his notice by signing below in order to proceed in	tructions" to Pfizer information from uthorize Pfizer Inc. icial qualifications dditional financial must affirmatively in the Pfizer Patient	copy of this Authoriz the signature on this prescribed by law). I a letter requesting s 75067, but that this through this Authorization	s form through t understand that uch cancellation cancellation will a zation. on for Financial	the enrollment I may cancel to to 2730 S. Eco not apply to an	t period (unless a shorter timeframe is his Authorization at any time by mailing thronds Lane, Suite 300, Lewisville, TX by information already used or disclosed a signature certifies that I have read and		
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  The information you provide will be used by Pfizer Inc. ("Pfizer"), the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility to manage and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to sen you materials and other helpful information and updates relating to Pfizer programs.  Patient Declaration - By signing below, I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. I understand that: Completing this enrollment form does not guarantee that I will qualify for the Pfizer Patient Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance provided and may ask for more financial and insurance protider of the prizer Patient Assistance Program, 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. I have a signed copy of a current and complete Authorization to Share Health Information about me with the Pfizer Patient Assistance Foundation. The Pfizer Patient	X	Nations or Dations Donroconstative)	Dationt Danrocan	tativo Namo (Dlaco	o Drint\		Doto.		
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to manage and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to sen you materials and other helpful information and updates relating to Pfizer programs.  Patient Declaration - By signing below, I certify that I cannot afford my medication, and I caffirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. I understand that: Completing this enrollment form does not puarantee that I will qualify for the Pfizer Patient Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by the Pfizer Patient Assistance Program shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program, 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 Prescriber so that meaning the 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 Patient Assistance 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 Patient Assistance Foundation Inc.  The Pfizer Patient Assistance Foundation Image Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation Image Program Pfizer Inc. with					ns 🗖 Other_				
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## PFIZER PATIENT ASSISTANCE PROGRAM'

patient access

TELEPHONE: 1-844-496-8707 FAX: 1-877-548-1734 ADDRESS: 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

Patient Authorization to Share Health Information – This must be signed and returned to Pfizer Dermatology Patient Access to receive assistance.

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit <a href="https://www.pfizer.com/privacy">www.pfizer.com/privacy</a>.

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 my insurer's prior authorization requirements
  - Assisting with identification of my insurer's requirements for appealing 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, Pfizer Dermatology Patient Access™ 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 Pfizer Dermatology Patient Access at 1-833-956-3376 or 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067. 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 Dermatology Patient Access and parties acting on their behalf, including using 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 Dermatology Patient Access and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer Dermatology Patient Access 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 Dermatology Patient Access at 1-833-956-3376.

refill reminders from Pfizer Dermatology Patient A opt in. See terms and conditions for mobile mess	r number, I consent to receive enrollment status, prescrip Access via text message. I will receive a welcome text asking saging at <u>Engagedrx.com/PDPA</u> and Pfizer's Privacy Policy at tes may apply. Text HELP to 82000 for information and STOP	me to reply YES to Pfizer.com/privacy.					
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*The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal ent	Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the P ity from Pfizer Inc. with distinct legal restrictions.	iizer Patient Assistance					
X							
Patient Signature (Patient or Patient Representative)	Patient Representative Name (Please Print)	Date					
If signed by patient representative, please indicate below the at ☐ Court Appointed ☐ Guardian ☐ Power of Attorney, includin							



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**HCP TO COMPLETE** 

Please complete the form where applicable and return via mail or fax. All pages must be returned to Pfizer Dermatology Patient Access™.

IMPORTANT NOTE: Commercially Insured patients are not eligible for assistance. Patients must have an FDA-approved diagnosis to be considered for the Pfizer Patient Assistance Program.

lacktriangle Check here if the patient is reapplying for the Pfizer Patient Assistance Program.

	Name & Title:			Specialty:					
PRESCRIBER INFORMATION (To be completed by the provider)	Payer Specific #: NPI #:		Tax ID #:						
	State License #:			DEA #:					
	Name of Facility:								
	Address:								
	City:			State:	ZIP:	P:			
	Contact Name:			Contact Phone:					
	Contact E-mail Address:			Fax:					
PRESCRIBER CERTIFICATION	The information you provide will be used by Pfizer Inc. ("Pfizer") to improve and tailor our products and services to better serve you. The information will also be used by the Pfizer Patient Assistance Foundation™ and parties acting on their behalf to administer and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.  By signing below, you, the Prescriber, understand and agree to the following: I will receive and secure my patient's medication at my office until it's dispensed to my patient, 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, nor will any cost related to it be applied toward the patient's true out-of-pocket costs (TrOOP). I certify that the information provided is current, complete, and accurate to the best of my knowledge. I certify that my decision to prescribe a Pfizer product is based solely on my independent clinical judgment and I have prescribed the product for an FDA-approved indication. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. If the patient has Medicare Part D, Pfizer will notify the Medicare Part D plan of their participation in the Pfizer Patient Assistance Program. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. Pfizer may contact the patient directly to confirm the receipt of medications. The information provided on this enrollment form is subject to random audits and verification. Pfizer ma								
	***************************************				Date:				
CUID TO	☐ Prescriber ☐ Patient ☐ Other (please provide shipping address—NO PHARMACIES):								
SHIP TO	Address:		State	).	ZIP:				
	City:				ZIF.				
	Patient First Name:		Patient Last Name:						
	Patient DOB:		Patient Phone:						
	Primary ICD-10:		Secondary ICD-10:						
CLINICAL AND PRESCRIPTION INFORMATION	Rx: ☐ CIBINQO™ (abrocitinib) 50-mg tablets PO QD, 30-day supply ☐ CIBINQO™ (abrocitinib) 100-mg tablets PO QD, 30-day supply		EUCRISA® (crisaborole) 60-g tube, 3  EUCRISA® (crisaborole) 100-g tube.		ube, 30-day supply	Refills (up to 11):			
	☐ CIBINQO™ (abrocitinib) 200-mg tablets PO QD, 30-day supply		<b>Directions for use</b> (please include location on body):						
	☐ LITFULO™ (ritlecitinib) 50-mg capsules PO QD, 28-day supply		picado molado issansin sin sociji.						
	Drug Allergies: Yes No If yes, please list medication(s) and associated reaction(s):								
	Patient's current medication(s):								
	Prescribing Physician Signature—NO STAMPS (Dispense as written):								
	Prescribing Physician Signature—NO STAMPS (I	Dispense as written):							

Note: If you are a New York prescriber, please attach state prescription form. e-Prescriptions should be sent to Sonexus Health Pharmacy Services, 2730 S. Edmonds Lane, Suite 400, Lewisville, TX 75067 (NCPDP: 5910206; NPI: 1447680210). If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying you have received patient consent for Sonexus Health Pharmacy Services and Pfizer Dermatology Patient Access to contact your patient and provide them services.

\*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.

