Pfizer enCompass®

STOP JUST LOOKING FOR CO-PAY ASSISTANCE?
Visit Pfizeriandicopay.com

Pfizer enCompass Enrollment Form for ABRILADA™ (adalimumab-afzb)

Please complete and fax this form to 1-844-482-4482 or mail to Pfizer Inc. ("Pfizer") at Pfizer enCompass, 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067
For assistance, call 1-844-722-6672, 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.

Please check the appropriate box(es) and complete the required fields on this enrollment form.

- ☐ Benefit investigation support (patients complete sections 1-4 and 7; healthcare providers complete sections 1-3 and 5)
- ☐ For prior authorization assistance (patients complete sections 1-4 and 7; healthcare providers complete sections 1-5)
- ☐ Pfizer enCompass Co-Pay Assistance Program (patients complete sections 1-5 and 7; healthcare providers complete sections 1-5). For patients only seeking co-pay assistance enrollment, assistance may be requested directly at pfizeriandicopay.com
- ☐ Referral for Interim Assistance (patients complete sections 1-4 and 7; healthcare providers complete sections 1-5)

For Patient to Complete

Go to patientportal.pfizerencompassonline.com to complete this form online

1. PATIENT INFORMATION (*INDICATES REQUIRED FIELD)

*Name (First, Middle Initial, Last) _____

*Sex ☐ Male ☐ Female ☐ Not Disclosed *Date of Birth (mm/dd/yyyy) _____ Email _____

*Street Address _____

*City _____ *State _____ *ZIP Code _____

*Primary Phone _____ ☐H ☐W ☐M Alternate Phone _____ ☐H ☐W ☐M Language Preference _____

☐ Patient Caregiver Caregiver Name _____ Caregiver Phone _____ Caregiver Email Address _____

Prescriber Name _____ Prescriber Phone Number _____ Prescriber Address _____

2. RESOURCES REQUESTED (PLEASE CHECK THE APPROPRIATE BOX[ES] FOR THE RESOURCES YOU WANT TO REQUEST. PAGE 4 MUST BE COMPLETED BY THE HEALTHCARE PROVIDER TO RECEIVE RESOURCES)

- ☐ **Welcome Kit** — Includes helpful materials to support you as you start treatment with ABRILADA.
- ☐ **Sharps Container** — Helps you safely store and dispose of used pens and syringes.
- ☐ **Travel Kit** — May make traveling with ABRILADA easier.
- ☐ **Nurse Injection Education** — ABRILADA Nurse Guides are available to provide post-prescription virtual and product injection education to eligible patients.
- ☐ **Demo Pen** — Pfizer enCompass provides an ABRILADA demo self-injection device so you can familiarize yourself with the process before your first injection.

How do you prefer to receive updates regarding your resources requested?

☐ **Text to Phone Number** _____ ☐ Email to Email Address _____

3. INSURANCE INFORMATION (PLEASE INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE AND PRESCRIPTION CARD[S], IF YOU HAVE INSURANCE) (*INDICATES REQUIRED FIELD)

☐ Check here if you do not have prescription coverage ☐ Check here if the patient has secondary prescription coverage

***Primary Insurance Name** _____

*Primary Insurance Phone Number _____ *Member ID # _____ *Group # _____

*Policyholder Name _____

*Policyholder Date of Birth (mm/dd/yyyy) _____ *Policyholder Relationship to Patient _____

Secondary Insurance Name _____

Secondary Insurance Phone Number _____ *Member ID # _____ *Group # _____

Policyholder Name _____

Policyholder Date of Birth (mm/dd/yyyy) _____ Policyholder Relationship to Patient _____

***Prescription (Rx) Insurance Name** _____ Prescription Insurance Phone Number _____

*Policy ID# _____ *Group # _____ *Rx BIN # _____ *Rx PCN # _____

*Policyholder Name _____ *Policyholder Date of Birth (mm/dd/yyyy) _____ *Policyholder Relationship to Patient _____

See next page to continue completing the Patient section of the Enrollment Form.

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*Patient Name (First, Middle Initial, Last) _____ *Patient DOB (mm/dd/yyyy)_____

4. PRIVACY NOTICE AND CONSENT TO PROCESS HEALTH INFORMATION AND PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing below/other affirmative act, you understand that Pfizer, Inc., the Pfizer Patient Assistance Foundation, Pfizer's affiliates, and its vendors (collectively, "Pfizer") will use the health information you and your healthcare providers provide us to provide you with the Patient Support Activities. You have the right to withdraw these permissions at any time and can do so by calling Pfizer enCompass at 844-722-6672. You can find more information about how Pfizer Inc. handles your personal information in our Privacy Policy at pfizer.com/privacy.

By using the boxes below, you can also agree to permit Pfizer to use the information you provide for additional specified purposes:

I understand that I have the right to withdraw my consent by calling Pfizer enCompass at 844-722-6672, and that if I withdraw my consent(s) it will be effective for any future disclosures but will not affect disclosures already made.

☐ **I understand and consent to the terms of the Privacy Notice and Consent to Process Health Information**

By signing this form, I agree to receive calls and texts from Pfizer or parties acting on its behalf, including calls and texts that use an autodialer or include artificial/prerecorded voice, to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, refill reminders from Pfizer enCompass, information and other Patient Support Activities (such as copay support or free drug programs) and for other non-marketing purposes (such as enrollment status and shipping updates) at the telephone number(s) I provide. I understand that my consent is not required and is not a condition of purchasing any goods or services from Pfizer. Message and data rates may apply. Text HELP to 82000 for information and STOP to opt out.

If I have a caregiver, he or she has also agreed to receive calls and texts, including calls and texts that use an autodialer or include artificial/prerecorded voice and hereby gives his or her permission for Pfizer, Pfizer enCompass, and/or parties acting on their behalf to contact him or her for such purposes at the phone number(s) provided. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer enCompass at 1-844-722-6672, Monday-Friday, 8AM - 8PM ET.

SIGN HERE

*Patient Signature (Patient or Patient Representative) *Print Name of Patient

Patient Representative Name
(Please print. Required if signing on behalf of the patient) *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_____

5. PATIENT CONSENT AND ATTESTATION IF REQUESTING CO-PAY ASSISTANCE (REQUIRED IF APPLYING FOR CO-PAY ASSISTANCE)

☐ 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 healthcare, 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 am not over 65 years of age and retired. I attest that I do not receive Social Security Disability (SSDI) or any other Social Security Administration (SSA) benefit. I further attest that I am not active duty military nor are any of my immediate family members.

☐ By checking this box, I confirm that I am eligible to participate in this program and agree to the Terms and Conditions specified here or available at www.pfizeriandicopay.com/TC. Please agree to the Terms and Conditions before proceeding.

How do you prefer to receive your Co-Pay Program Welcome Message?
☐Text to Phone Number _____ or ☐ Email to Email Address _____

SIGN HERE

*Patient Signature (Patient or Patient Representative) *Print Name of Patient

Patient Representative Name
(Please print. Required if signing on behalf of the patient) *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 have questions relating to your eligibility for the Pfizer enCompass Co-Pay Assistance Program for ABRILADA, you can contact Pfizer enCompass and provide your commercial insurance information to verify eligibility. Terms and Conditions apply. For full Terms and Conditions for ABRILADA, please see www.pfizeriandicopay.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.

6. PATIENT ACCESS COORDINATOR (PAC) OPT-IN

When you enroll in Pfizer enCompass, you have the option to be contacted by a Pfizer Patient Access Coordinator (PAC), who can help you understand your insurance benefits and navigate the process to access your ABRILADA. PACs are field-based employees of Pfizer and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. PACs are very familiar with access and reimbursement requirements for ABRILADA, and the PAC assigned to you will coordinate with Pfizer enCompass and you on your journey to starting therapy (although you will still need to contact Pfizer enCompass directly if you are seeking financial assistance). Working with a PAC is optional. Even if you choose not to opt in for this support, you may still access all patient support programs you are eligible for by working with an Access Counselor at Pfizer enCompass.

☐ Yes ☐ No I request PAC support and agree to receive telephonic communications from the PAC assigned to my case as described above. I understand that my consent is not required or a condition for purchasing any Pfizer goods or services. I understand that I can opt out of support from, and communications with, the PAC at any time by contacting Pfizer enCompass at 1-844-722-6672.

See next page to continue completing the Patient section of the Enrollment Form.

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.

Read, sign, date, and return the Patient Authorization form to Pfizer enCompass. This is required to request assistance.

7.*PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

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 (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
- 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's 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 enCompass 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. 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 state law requires a shorter period, or 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 enCompass at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067 or at 1-844-722-6672, 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 will receive a signed copy of this form.

SIGN HERE

_____ _____

***Patient Signature** (Patient or Patient Representative) ***Print Name of Patient**

_____ _____

Patient Representative Name
(Please print. Required if signing on behalf of the patient) ***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 _____

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Healthcare Provider to Complete

Go to www.pfizerencompassonline.com to complete this form online

1. HEALTHCARE PROVIDER INFORMATION (*INDICATES REQUIRED FIELD)

*Prescriber Name (First, Middle Initial, Last) _____ HCP Specialty _____

*Practice/Institution Name _____ *Street Address _____

*City _____ *State _____ *Zip Code _____

*NPI # _____ *Group Tax ID # _____

*Fax _____ *Email _____

*Office Contact Name _____ *Office Contact Phone _____

*Office Contact Email _____

2. PRESCRIPTION INFORMATION (PLEASE COMPLETE ALL BOXES AND INCLUDE PRESCRIPTION WHEN REQUESTING ASSISTANCE THROUGH INTERIM CARE, TRANSFER TO A SPECIALTY PHARMACY, OR IF THE PATIENT IS REQUESTING PATIENT RESOURCES LISTED ON PAGE 2.) (*INDICATES REQUIRED FIELD)

*Patient Name (First, Middle Initial, Last) _____ *Patient DOB (mm/dd/yyyy) _____

*Primary ICD-10 Diagnosis Code _____ Secondary ICD-10 Diagnosis Code _____

☐ Rheumatoid Arthritis ☐ Juvenile Idiopathic Arthritis ☐ Ankylosing Spondylitis ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Plaque Psoriasis
☐ Hidradenitis Suppurativa ☐ Uveitis ☐ Psoriatic Arthritis

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

Patient's Concurrent Medications: _____

☐ ABRILADA 40 mg/0.8 mL in a single-dose pen (2 count carton) ☐ ABRILADA 40 mg/0.8 mL in a single-dose pen (1 count carton)
☐ ABRILADA 40 mg/0.8 mL in a single-dose prefilled glass syringe (2 count carton) ☐ ABRILADA 20 mg/0.4 mL in a single-dose prefilled glass syringe (2 count carton)

Directions: Inject _____ mg of ABRILADA Route: Subcutaneous Frequency: _____ Quantity: _____ Refills: _____

FOR INTERIM CARE:

☐ ABRILADA 40 mg/0.8 mL in a single-dose pen (2 count carton) ☐ ABRILADA 40 mg/0.8 mL in a single-dose prefilled glass syringe (2 count carton)
☐ ABRILADA 20 mg/0.4 mL in a single-dose prefilled glass syringe (2 count carton)

Directions: Inject _____ mg of ABRILADA Route: Subcutaneous Frequency: _____ Quantity: _____ Refills: up to 2

3. PRESCRIPTION SIGNATURE (REQUIRED IF REQUESTING ASSISTANCE THROUGH INTERIM CARE, TRANSFER TO A SPECIALTY PHARMACY, OR IF THE PATIENT IS REQUESTING PATIENT RESOURCES LISTED ON PAGE 2. NO STAMPS ALLOWED) (*INDICATES REQUIRED FIELD)

Please Note: e-Prescribe ID (NCPDP: 5910206; NPI: 1447680210). If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying that you have received patient consent for Sonexus Health Pharmacy Services and Pfizer enCompass to contact your office, patient and provide them services. Sonexus Health Pharmacy Services is categorized as a retail pharmacy in EMR/EHR systems and is located at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067.
New York prescribers must e-prescribe.

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.

_____	_____
***Prescriber's Signature** Dispense as Written	***Date**
_____	_____
Prescriber's Signature Substitution Allowed	**Date**

See next page to continue completing the Healthcare Provider section of the Enrollment Form.

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*Patient Name (First, Middle Initial, Last) _____ *Patient DOB (mm/dd/yyyy) _____

4. PREFERRED SPECIALTY/RETAIL PHARMACY (*INDICATES REQUIRED FIELD)

☐ This prescription has been sent to a Specialty Pharmacy Provider (SPP) SPP Name _____ SPP Phone Number _____

If the prescription has not been sent to an SPP, please provide the information below if there is a preferred pharmacy:

Preferred Specialty/Retail Pharmacy Name _____

Preferred Specialty/Retail Pharmacy Phone Number _____

Preferred Specialty/Retail 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 fax to a specialty pharmacy approved by this plan. If there is no preferred specialty pharmacy indicated, then fax to any specialty pharmacy approved by this patient's plan.

5. HEALTHCARE PROVIDER SIGNATURE (*INDICATES REQUIRED FIELD)

I give my permission to receive calls related to these services from Pfizer, Pfizer enCompass, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

SIGN HERE

_____ _____

*Prescriber's Signature *Date

Interim Care

The Interim Care Program may provide new, eligible patients with up to 90 days of free ABRILADA shipping directly to patients (or HCPs for physician-administered drugs) who have provided a completed Interim Care Program ABRILADA prescription and who are actively experiencing a delay in coverage determination.

Interim Care Program Terms and Conditions

- The Interim Care Program is not health insurance and is available for eligible, commercially insured patients only.
- Offer is only available to patients who have been diagnosed with an FDA-approved indication for ABRILADA.
- No claim for reimbursement for product dispensed pursuant to this offer may be submitted to any third-party payer.
- Not available to patients covered under government plans such as Medicaid, Medicare, or other federal or state healthcare programs, including any state prescription drug assistance programs and the Government Health Insurance Plan or for residents of Massachusetts, Michigan, Minnesota, or Rhode Island.
- Available in up to a 30-day supply. Refills are subject to limitations.
- Participation in the Interim Care Program does not require, and is not contingent upon, purchase requirements of any kind.
- Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification.
- Interim Care Rx can only be dispensed by the exclusive pharmacy and only after a delay occurs in the prior authorization or appeals process. If an appeal is required, the insurer must allow appeals and the HCP must confirm that they are proceeding with the appeal process in order for the patient to be/remain eligible.
- Offer good only in the U.S. and Puerto Rico.
- Prescription must be provided by a healthcare provider licensed in the U.S. or Puerto Rico.
- Continued eligibility for the program requires the submission of an appeal within no more than 30 days of enrollment. The program provides up to a maximum of 3 months of product.
- The Interim Care Program is applicable to all ABRILADA presentations.

Additional eligibility criteria may apply. Contact Pfizer enCompass for details.