SOMAVERT®
(pegvisomant for injection)

PFIZER BRIDGE PROGRAM®
ENROLLMENT FORM

HOW TO COMPLETE

✔ **All pages must be completed and sent to the Pfizer Bridge Program. The Special Instructions box is optional per the available selections below.**

SPECIAL INSTRUCTIONS (Patient signature may be required to discuss some or all of these patient services):

- **Benefits Verification (BV) ONLY:** If a BV is requested, the Patient Care Coordinator can investigate insurance coverage for patients and will reach out to review and help them understand coverage options.
- **Patient Injection Training Requested:** A qualified nurse will provide one-on-one, in-home or virtual training on how to inject, as well as guidance on getting accustomed to therapy and setting up a routine.
- **SOMAVERT Copay Program*:** Eligible, commercially insured patients may pay as little as $5 per month with a maximum benefit of $20,000 per calendar year through the copay program. Click here for terms and conditions.
- **Dose Change:** If your patient has already been prescribed but you need to request a dose change, select this box.

*Eligibility required. Eligible patients may pay as little as $5 per month and assistance may be up to a maximum of $20,000 per calendar year. State and federal health care program beneficiaries not eligible even if they elect to be processed as an uninsured (cash-paying) patient. Terms and conditions apply. The savings program is not health insurance. No membership fees. Pfizer reserves the right to rescind, revoke or amend this offer without notice. Offer expires 12/31/2023. For more information, visit our website www.somavert.com, call 1-800-645-1280 or visit Pfizer.com. Somavert Copay Program, PO Box 220746, Charlotte, NC 28222-0746. Click here for terms and conditions.

✔ **When selecting a prescription, please make sure to choose either dose or dose titration. If selecting loading dose, please indicate the shipment location.**

✔ **Have the patient sign the Patient Authorization to Share Health Information and send to the Pfizer Bridge Program with the completed form.**

Fax completed forms to
the Pfizer Bridge Program
at 1-800-479-2562

OR

Mail to the Pfizer Bridge Program
PO Box 220746
Charlotte, NC 28222

You may access additional forms at
www.somaverthcp.com

By enrolling in the Pfizer Bridge Program, patients will receive various support and information to help access SOMAVERT, which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Providing benefits verification and reimbursement support, including:
  - Assisting with identification of the patient's insurer's prior authorization requirements
  - Assisting with identification of the patient's insurer's requirements for appealing a denied claim
- Determining eligibility for and helping eligible patients access copay support or free drug programs
- Sending the patient starter kit (where appropriate)
- Communicating with the patient's Healthcare Providers about SOMAVERT and Patient Support Activities
- Providing the patient with financial assistance resources and information, if eligible
- Providing the patient with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending the patient surveys about their experience with Pfizer products, services, and programs

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

FOR ENROLLMENT INTO THE PFIZER PATIENT ASSISTANCE PROGRAM
CALL THE PFIZER BRIDGE PROGRAM AT 1-800-645-1280 | MON–FRI, 9 AM–7 PM ET

SOMAVERT®
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PFIZER BRIDGE PROGRAM®
ENROLLMENT FORM

TO BE COMPLETED BY PATIENT

For assistance or additional information, call 1-800-645-1280, Monday–Friday, 9 AM –7 PM ET.

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SPECIAL INSTRUCTIONS

- ☐ Benefits Verification ONLY
- ☐ SOMAVERT Copay Program
- ☐ Patient Injection Training Requested
  - ☐ In-Home Training
  - ☐ Virtual Training
- ☐ Dose Change

❶ PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

DOB (mm/dd/yyyy) _____ Gender ☐ M ☐ F Parent/Guardian Name _____

Address _____ City _____ State _____ ZIP Code _____

Primary Phone _____ ☐ H ☐ W ☐ M Alternate Phone _____ ☐ H ☐ W ☐ M

Email _____ Preferred Language (if not English) _____

Caregiver Name _____ Caregiver Phone _____ ☐ H ☐ W ☐ M

Caregiver Email _____

❷ INSURANCE INFORMATION

☐ **INSURANCE CARD(S) ATTACHED** ☐ **CHECK IF PATIENT DOES NOT HAVE PRESCRIPTION COVERAGE** ☐ **CHECK IF PATIENT HAS SECONDARY PRESCRIPTION COVERAGE**

Primary Insurance _____ Insurance Phone _____

Policy ID # _____ Group # _____

Policy Holder First Name _____ Policy Holder Last Name _____

Policy Holder DOB _____ Policy Holder Relationship to Patient _____

Prescription Drug Insurer _____ Phone _____

Policy ID # _____ Group # _____

Rx BIN # _____ Rx PCN # _____

Patient's Preferred Specialty Pharmacy _____ ☐ Self-Dispensing Pharmacy

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 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.

❸ PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing this form, I agree to communications from Pfizer, the Pfizer Bridge Program, 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 copay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer, the Pfizer Bridge Program, 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, they have also agreed to receive such communications from Pfizer, the Pfizer Bridge Program, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, the Pfizer Bridge Program, 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 the Pfizer Bridge Program at 1-800-645-1280.

_____ _____ _____

Print Name of Patient | Date | Patient Email (if signing electronically)

SIGN

_____ _____

Patient Signature (Patient or personal representative of patient) | Relationship to Patient

If signed by patient representative, please indicate below the authority to act on behalf of the patient:

☐ Court Appointed ☐ Guardian Power of Attorney including authority to make healthcare decisions ☐ Other _____

PLEASE COMPLETE AND FAX THIS FORM, ALONG WITH A COVER SHEET, TO 1-800-479-2562 OR MAIL TO PO BOX 220746, CHARLOTTE, NC 28222.

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4 PFIZER PATIENT ACCESS COORDINATOR (PAC) OPT-IN FORM

When you enroll in the Pfizer Bridge Program®, 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 prescribed medication. Pfizer PACs are field-based employees of Pfizer Rare Disease and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. Pfizer PACs are very familiar with access and reimbursement requirements for SOMAVERT® (pegvisomant for injection), and the Pfizer PAC assigned to you will coordinate with the Pfizer Bridge Program and you on your journey to starting therapy (although you will still need to contact Pfizer Bridge Program directly if you are seeking financial assistance).

Working with a Pfizer 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 a case manager at the Pfizer Bridge Program.

If you opt in, the Pfizer PAC may need to access, review, use, and/or share information about you, the patient, including:

- Limited personal information, such as your name, date of birth, and phone number, to inquire about your case on your behalf
- Limited health information specific to your diagnosis and treatment, such as your treating physician and medication

Pfizer PACs may need to access, review, use, and/or share this information in order to:

- Keep you informed about the status of your case and medication
- Obtain any information missing from your Pfizer Bridge Program enrollment form
- Review your insurance coverage for your medication, including out-of-pocket costs and other payer requirements
- Provide information to you in the event that your insurer denies coverage for your medication
- Explain next steps for you to receive your medication from a specialty pharmacy
- Connect you to Pfizer Bridge Program in the event that you request financial assistance or express concerns about affording your medication
- Contact you periodically to manage reauthorization processes as determined by your insurer
- Address other questions or issues you may have about accessing your medication

Pfizer PACs do not provide medical advice and will recommend that you raise any treatment-related questions directly with your healthcare provider.

By signing below, you, the patient, understand and agree to the following:

- I request Pfizer PAC support and agree to receive telephonic communications from the Pfizer 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 Pfizer PAC at any time by contacting Pfizer at 1-800-645-1280
- I understand that in order to request Pfizer PAC support, I must also submit a completed SOMAVERT enrollment form

Patient Name (Print) _____

SIGN Patient Signature _____ Date _____

Contact Preference ☐ Email ☐ Phone (calls only)

Email _____ Phone _____ ☐ Home ☐ Mobile ☐ Work

Address _____ City _____ State _____ ZIP Code _____

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PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

TO BE COMPLETED BY PATIENT

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 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 copay 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 Bridge Program® 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 Bridge Program at 1-800-645-1280 or PO Box 220746, Charlotte, NC 28222. 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 Bridge Program, 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 copay 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, the Pfizer Bridge Program, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, the Pfizer Bridge Program, 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 the Pfizer Bridge Program at 1-800-645-1280.

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.

Patient Name _____ Date _____ Patient Email (if signing electronically) _____

SIGN

Signature: Patient/Certification of person legally authorized to sign for patient _____ Relationship _____

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PFIZER BRIDGE PROGRAM® ENROLLMENT FORM

TO BE COMPLETED BY HCP

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Patient Full Name _____ Patient DOB (mm/dd/yyyy) _____

5 PRESCRIBER INFORMATION

*Required field

*Prescriber First Name _____ *Prescriber Last Name _____ Prescriber NPI # _____

*Specialty _____ Group Tax ID # _____ *State License # _____

*Practice Name _____ Office Contact _____

*Address _____ *City _____ *State _____ *ZIP Code _____

*Phone _____ Fax _____

6 DIAGNOSIS DO NOT ATTACH ANY CLINICAL OR OFFICE NOTES AS THIS MAY DELAY PROCESSING THE FORM

☐ Acromegaly (E22.0) ☐ Neoplasm, benign pituitary (D35.2)

7 PRESCRIPTION OPTIONS

☐ **Loading dose** (subcutaneous injection): 40-mg loading dose (20-mg vial x2)

Loading dose shipment: ☐ Patient's Home ☐ Physician Office ☐ Other: _____

	Dose	Packaging
☐ **Daily Dose** OR ☐ **Dose Titration** (subcutaneous injection):	☐ 10 mg/day ☐ 15 mg/day ☐ 20 mg/day ☐ 25 mg/day ☐ 30 mg/day	☐ One Day Package ☐ 30-Day Package

Days supply _____ Refills _____ Start date ____/____/____

8 HEALTHCARE PROVIDER CONSENT This form cannot be processed without healthcare provider's 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 further certify that any support provided through the Pfizer Bridge Program on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use SOMAVERT or any other Pfizer product or service for anyone. 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 _____ _____

Prescriber Signature: NO STAMPS **(Dispense as Written)** Date
If you are a New York prescriber, please use an Original New York State Prescription form.

_____ _____

Print Name of Healthcare Provider Prescriber Email (if signing electronically)

9 HEALTHCARE PROVIDER CONSENT TO SHARE HEALTH INFORMATION & RECEIVE COMMUNICATIONS

This form cannot be processed without healthcare provider's signature

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 copay support or free drug programs, for which the patient may be eligible, and other support for SOMAVERT.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, the Pfizer Bridge Program, and/or 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, the Pfizer Bridge Program, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

SIGN _____ _____ _____

Prescriber Signature Date Prescriber Email (if signing electronically)

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