Patient Support Enrollment Form

XELSOURCE℠
Answers and Support

Phone 1-844-935-5269 | Fax 1-866-297-3471 | 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

When applicable, check the box(es) below to be directed to appropriate sections to enroll patients in the following services provided by XELSOURCE. XELSOURCE will assess the patient based on their needs.

☐ **Benefits Verification, Prior Authorization, and/or Appeals Assistance** – We'll determine the patient's health insurance coverage and out-of-pocket costs, share with patient, and fax a summary of benefits to the healthcare provider (HCP) office.

☐ **Pfizer Patient Assistance Program (PAP)**†
Is the patient uninsured or government insured and cannot afford their medication? ☐ **Yes** ☐ **No**

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

- Meet one of the following:
  - Have no, or not enough, government insurance coverage to pay for their Pfizer medicine
  - Have been denied coverage by their government insurer (after at least two unsuccessful appeals to their insurer)
- Reside in the U.S. or a U.S. territory
- Be prescribed by a healthcare provider licensed in the U.S. or a U.S. territory & treated in an outpatient setting
- Have an FDA-approved indication for the prescribed product
- Patient's income must be <500% of the federal poverty level
- Patients should visit **xelsourcepatientportal.com** to apply or re-enroll
- HCPs may request re-enrollment for PAP patients by going to **xelsourceportal.com**

NOTE: Commercially insured patients are not eligible for the Pfizer PAP.‡

†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.

‡Commercially insured patients who were enrolled in the Pfizer PAP prior to January 1, 2023 may still be eligible for the PAP if they continue to meet all eligibility criteria.

☐ **Voucher Program**§ – Patients who are new to XELJANZ® (tofacitinib) are eligible to receive a one-time, 30-day supply of XELJANZ with a valid prescription.

§A one-time, 30-day supply for patients new to XELJANZ. MA residents may select their pharmacy. Otherwise, this free trial will be supplied through XELSOURCE.

Tips for Completing the Enrollment Form

PATIENT INSTRUCTIONS

Go to **xelsourcepatientportal.com** to complete the form online. By completing this step, you **do not** need to complete the paper enrollment form.

Page 1:

- Complete all necessary patient AND insurance fields
- Review AND sign the Patient Authorization to receive communications from XELSOURCE

Page 2:

- Authorize by signing required AND applicable sections
- Authorize Electronic Income Verification in section 5 by checking the box AND providing your signature
  - If box isn't checked AND form isn't signed, income documentation is required

Page 3:

- Read, sign, AND date the Patient Authorization to Share Health Information Form

FAX COMPLETED FORMS TO **1-866-297-3471**

OR MAIL TO: 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

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 Support Enrollment Form

XELSOURCE℠
Answers and Support

Phone 1-844-935-5269 | Fax 1-866-297-3471 | 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

PATIENT TO COMPLETE

Go to **xelsourcepatientportal.com** to complete this form online

1 PATIENT INFORMATION Complete all required fields

*Required field

First Name* ______ Middle Name ______ Last Name* ______

DOB (mm/dd/yyyy)* ______ Gender* ☐ M ☐ F U.S./Puerto Rico/Guam/U.S.V.I. Resident*: ☐ Yes ☐ No

Address* ______ City* ______ State* ______ ZIP* ______

Primary Phone* ______ ☐ H ☐ W ☐ M Alternate Phone ______ ☐ H ☐ W ☐ M

Email ______ Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Preferred Language (if not English) ______ Caregiver Name ______ Caregiver Relationship ______

Caregiver Phone ______ ☐ H ☐ W ☐ M Caregiver Email ______

2 INSURANCE INFORMATION This section is not required for Voucher Rx only.

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

INSURANCE TYPE: ☐ **Commercial (Not PAP† eligible)** ☐ **Medicare Part D** ☐ **Medicaid** ☐ **Other** ______ ☐ **N/A**

	Primary Medical Insurance	Primary Prescription Insurance	Secondary Prescription Insurance
Insurance Name*			
Phone*			
Policy ID #*			
Group #*			
Policyholder Name*			
Relationship to Patient			
Policyholder DOB			
BIN #*			
PCN #*			

Medicare Part D Address (if applicable) ______

Preferred Pharmacy ______

Address ______ City ______ State ______ ZIP ______

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

3 PATIENT AUTHORIZATION TO RECEIVE COMMUNICATIONS*

By signing this form, I agree to communications from Pfizer, XELSOURCE, 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, XELSOURCE, 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, XELSOURCE, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, XELSOURCE, 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 XELSOURCE at 1-844-935-5269.

☐ XELSOURCE: By checking this box and providing my cellular number, I consent to receive autodialed non-marketing texts from Pfizer and its service providers regarding enrollment status, prescription updates, and refill reminders from XELSOURCE at the phone number provided. I may receive a welcome text asking me to reply YES to opt-in. Up to 10 messages/month. Message and data rates may apply. Complete terms can be found at https://m.enrollsource.com/pfe and Pfizer's privacy policy at www.pfizer.com/privacy. Text STOP to opt out.

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 ______

†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.

FAX COMPLETED FORMS TO **1-866-297-3471** OR MAIL TO: 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

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 Support Enrollment Form

XELSOURCE℠
Answers and Support

Phone 1-844-935-5269 | Fax 1-866-297-3471 | 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

PATIENT TO COMPLETE

Go to **xelsourcepatientportal.com** to complete this form online

❹ PATIENT FINANCIAL INFORMATION (Pfizer Patient Assistance Program [PAP] applicants only)

*Required field

Total Number of People Within Household (including applicant): ____________ **Total Annual Income for Entire Household: $** ________________

The annual household income includes all income sources for all members of the household such as current annual salary, Social Security, unemployment insurance benefits, IRA distributions, and workers' compensation.

IF YOU DO NOT WANT YOUR INCOME TO BE VERIFIED ELECTRONICALLY, you must mail or fax documentation to support the financial information. If we cannot complete a successful Electronic Income Verification (see Section 5 below), we will request proof of income documentation from you to determine eligibility for assistance.

Attached is: ☐ **Most recent federal tax return (1040 form)** ☐ **W-2 form** ☐ **Other**

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.

❺ PATIENT AUTHORIZATION FOR ELECTRONIC INCOME VERIFICATION (PAP applicants only)

Optional, but may reduce application review time. If box isn't checked and form isn't signed, income documentation is REQUIRED.

☐ By checking this box and signing below, I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Reporting Act, authorizing Pfizer Inc. to obtain information from my credit profile or other information from Experian® Income View℠. I authorize Pfizer Inc. 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 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, 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 ______________________

❻ PFIZER PATIENT ASSISTANCE PROGRAM† PATIENT AUTHORIZATION (PAP applicants only)

The information you provide will be used by 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 send 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 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 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. **I certify and attest that if I receive medicine(s) provided by Pfizer through the Pfizer Patient Assistance Program:** 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 true out-of-pocket costs (TrOOP) for prescription drugs. I will not submit claims, 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 Form on record with my Prescriber so that my Prescriber may share health information about me with the Pfizer Patient Assistance Program, Pfizer Inc., and the Pfizer Patient Assistance Foundation™ Inc.

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 ______________________

❼ PATIENT ACCESS COORDINATOR (PAC) OPT-IN

When you enroll in XELSOURCE, 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 XELJANZ® (tofacitinib). 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 XELJANZ, and the PAC assigned to you will coordinate with XELSOURCE and you on your journey to starting therapy (although you will still need to contact XELSOURCE 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 a case manager at XELSOURCE

☐ By checking this box, 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 XELSOURCE at 1-844-935-5269.

†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.

FAX COMPLETED FORMS TO **1-866-297-3471** OR MAIL TO: 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

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 AUTHORIZATION TO SHARE HEALTH INFORMATION

XELSOURCE[SM]
Answers and Support

PATIENT TO COMPLETE

Phone 1-844-935-5269 | Fax 1-866-297-3471 | 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

Go to xelsourcepatientportal.com to complete this form online or please complete the form where applicable and return via mail or fax. Please return all pages to XELSOURCE.

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.

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 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 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, XELSOURCE 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 XELSOURCE at 1-844-935-5269 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, XELSOURCE, and parties acting on their behalf, including text message, email, a live operator, 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, XELSOURCE, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, XELSOURCE, 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 XELSOURCE at 1-844-935-5269.

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 ____________

PP-XEL-USA-8504 © 2023 Pfizer Inc. All rights reserved. February 2023