Pfizer Oncology together™

Completing the Enrollment Form. Together.

A guide to requesting:

- Co-Pay Assistance
- Reimbursement Support – Benefit Verification, Prior Authorization/Appeals Assistance
- Pfizer Patient Assistance Program (PAP)* Enrollment
- Patient Resources – Care Champions

Get started with the appropriate color-coded sections

Patient: Green
Healthcare Provider (HCP): Blue

1 OF 7

Pfizer Oncology together™

JUST LOOKING FOR CO-PAY ASSISTANCE? Visit PfizerCopay.com

Patient Support Program & Patient Assistance Enrollment Form

What assistance does the patient need? Check all that apply:

For Co-Pay Savings for Injectables visit PfizerCopay.com
☐ Benefits Verification (BV)
☐ Uninsured Patient: Pfizer Patient Assistance Program
☐ Care Champion Program
☐ Government Insured Financial Assistance: BV completed, patient understands copay and cannot afford

Overview

Pfizer Oncology Together is a personalized patient support program that offers resources for patients prescribed Pfizer Oncology medicines. We provide access and reimbursement support, as well as help identifying financial assistance options for certain products, so eligible patients can get their prescribed Pfizer Oncology medicines.

For RUXIENCE and ZIRABEV, the Prescribing Information does not include all of the indications of the original manufacturer's product. Please see Section 20 (Page 6) to confirm and acknowledge program limitations.

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.

Pfizer Oncology Together Patient Services

By enrolling in Pfizer Oncology Together, patients will receive various support and information to help access certain Pfizer medicines, which may include the following, depending on the product/program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of the insurer's prior authorization requirements
  - Assisting with identification of the insurer's requirements for appealing a denied claim
- Communicating with Healthcare Providers (HCPs) about a Pfizer medicine and Patient Support Activities
- Provision of financial assistance resources and information, if eligible
- Determining eligibility for and helping with access to co-pay support or free drug programs (including the Pfizer Patient Assistance Program*)
- One-on-one assistance to help address day-to-day needs (opt-in required)
- Provision of disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending surveys about the patient's experience with Pfizer products, services, and programs

Patients Eligible 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 by signing and dating Section 13 on Page 5 of this 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)

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

†Eligibility criteria are subject to change at any time.

Your Color Coding Guide

Color coding indicates which sections of the form should be filled out by the **Patient** or the **HCP**

*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.

If requesting Copay Savings Program for Injectables only, please visit PfizerCopay.com.

The enrollment form is available at **PfizerOncologyTogether.com/hcp** and on the provider portal at **PfizerOncologyPortal.com**.

Patient and HCP: Please sign and date the required section(s) for your consent. If necessary and only where noted, a missing signature may be provided electronically with a valid email address in the space(s) provided. If we receive an incomplete form, we'll contact you and your patient for the missing information.

Fax to **1-877-736-6506**, submit through the Documents Portal by going to **patientsupportnow.org/patient/** and entering the code **8777366506**, or 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.

When completing the HCP sections of the enrollment form, please include the following information for the medication prescribed.

ORALS

- Prescription information Sections 14-16

INJECTABLES

- Ordering information Sections 17-18

INJECTABLE—BIOSIMILARS

- Diagnosis section for important prescription disclosures, Section 20
- Ordering information and certification of request for assistance from Pfizer Patient Assistance Program,* Sections 21-24

The Drug Replacement Program is available for eligible patients who are enrolled in the PAP and requires a completed enrollment form **prior to treatment**. The Drug Replacement Program provides product replacement for eligible patients when a patient is denied coverage for Pfizer injectable medications through at least one level of appeal. Call Pfizer Oncology Together to learn more about the program.

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FOR INSTRUCTIONAL PURPOSES ONLY

For Patients *(Page 2)*

Be sure that patient reviews

Privacy Statement ✔

Enrollment Checklist for Patients ✔

A Patient Information

Provide the required information. Ensure the patient provides their Preferred Language, if other than English, and Caregiver Information

B Patient Insurance Information

Commercially Insured Patients are not eligible for PAP*

C Financial Information

Enables search for alternate funding support and/or verifies eligibility for PAP. This is required if requesting assistance through PAP

D Co-Pay Savings Program for Injectables

Reminder: If the patient is just looking for co-pay assistance, visit PfizerCopay.com

Pfizer Oncology together™ **TO BE COMPLETED BY PATIENT** 2 OF 7

For questions, please 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.**

Enrollment Checklist for Patients

Pages 2 and 3 should be completed by the patient or their caregiver. When completing these pages, keep the following points in mind:

- Include copies of the front and back of your medical and pharmacy insurance cards
- To apply for the PAP, review **Section 5** and sign if you consent to Electronic Income Verification. If you don't, you will need to provide proof of income documentation in **Section 3**
- Review **Section 5** and check the box if you would like to opt in to the Care Champion program
- Check the appropriate boxes in **Section 5** if you would like to sign up for text message alerts from the Pfizer Patient Assistance Program and/or from Pfizer Oncology Together Care Champion
- Read all Patient Authorizations, Attestations, and Disclosures, then sign in **Section 5** to provide your consent

1. Patient Information *Required fields

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.

Check insurance type: ☐Commercial ☐Medicare ☐Medicaid ☐Other ________ ☐None (skip to Section 3)

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* | Insurer's Phone*

Policy/Medicare Beneficiary ID #* | GRP ID #*

Policyholder same as patient? ☐Yes ☐No | Relationship to Patient

Policyholder Name* | Policyholder DOB (mm/dd/yyyy)

Secondary Insurance* | Insurer's Phone*

Policy/Medicare Beneficiary ID #* | GRP ID #*

Policyholder same as patient? ☐Yes ☐No | Relationship to Patient

Policyholder Name* | Policyholder DOB (mm/dd/yyyy)

Prescription Insurance Name* | Prescription Policy ID #*

Prescription Group ID #* | Prescription BIN # | Prescription PCN #*

Are you enrolled in a Medicare Part D Prescription Drug Plan? ☐Yes ☐No (If Yes, please complete the information below. If No, skip to Section 3)

Provide your Medicare ID Number (HICN) or Medicare Beneficiary Number (MBI)

Medicare Part D Plan Name

Medicare Part D Plan Address

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

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

My provider or pharmacy has reviewed my insurer required copayment 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 5, you must submit documentation 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. Pfizer Oncology Together Co-Pay Savings Program for Injectables

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 product or check the appropriate boxes below: 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 copay 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.

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

*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 Patients *(Page 3)*

A **Personalized Patient Support Opt-in** (Optional)

- Activates additional support through the Care Champion Program*
- Authorizes text messages from the Care Champion Program

B **PAP Certification, Attestation, and Privacy Disclosures**

- Certifies accuracy of information for PAP† and authorizes text messages to the patient with refill reminders and medication shipping information‡
- Only sign if applying for PAP

C **REQUIRED: Patient Consent to Receive Communication**

Authorizes communications from the Pfizer Oncology Together Program

D **Patient Authorization for Electronic Income Verification**

Authorizes Pfizer Oncology Together to electronically verify the patient's income when applying for PAP. Patients can either opt into Electronic Income Verification **or** attach supporting financial documentation when applying for PAP. See Section 3 for more information

Pfizer Oncology together™ **TO BE COMPLETED BY PATIENT** 3 OF 7

For questions, please 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.**

A **5. Patient Authorizations, Attestations, and Disclosures** *Required fields

Personalized Patient Support Opt-in (Optional)

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.

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.

B **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 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.

☐ 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 (______) ______ - _________.

C **Patient Consent to Receive Communications**

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.

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:

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

I, the applicant name 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.

Patient Signature* (Patient or 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:

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Patient Authorization to Share Health Information Form (page 7)

This form is required to request assistance. Have the patient read, sign, and date this form. Then send it to Pfizer Oncology Together.

*For more information on services offered through the Care Champion program, please visit PfizerOncologyTogether.com/hcp and click on Patient Support.

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‡PAP refill reminder text messages are only available for patients who have been prescribed Pfizer Oncology oral medications and are participating in PAP.

For HCPs *(Page 4)*

Healthcare professionals should read and complete all Sections on this page

Review the
Enrollment Checklist for HCP

A HCP/Site of Care Information

If Site of Care does not apply, check N/A

B Shipping Information for PAP* Patients

Select appropriate shipping address

C HCP HIPAA and Telephone Consumer Protection Act (TCPA) Attestation

Sign and date to attest that you have obtained the necessary authorizations and consents from the patient

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Pfizer Oncology together™ **TO BE COMPLETED BY HCP** 4 OF 7

For questions, please 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.**

Enrollment Checklist for HCP

Fill out every section of this page for all patient enrollment requests. Read the **Privacy and Consent** statements in **Sections 9 and 10** and sign below. On the following pages:

- **Diagnosis:** Specify diagnosis in **Section 12** for Oral and/or Injectable medications, and in **Section 20** for Injectable Biosimilar Medications. For RUXIENCE or ZIRABEV: Check the box and sign to acknowledge program limitations.
- **Directions/Dosing Instructions:** Complete **Section 14** for Orals and/or **Section 18** for Injectables
- **Sign the Prescription:** Sign **Section 15** for Orals
- **Pfizer Patient Assistance Program:** For patients requesting enrollment for Orals and/or Injectables, **Sections 8** and **13** are required. For patients requesting enrollment for Injectable Biosimilars, **Sections 8, 23,** and **24** are required. Patients must be uninsured or government insured and unable to afford their co-pay to be considered.

6. 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 copay and have they directly communicated that they are unable to afford this? ☐Yes ☐No

A 7. 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*

B 8. Shipping Information for Pfizer Patient Assistance Program (PAP) Patients Required if requesting assistance through the Pfizer Patient Assistance Program.†

Patient Name*
Ship To*: ☐HCP/Site of Care Address (Section 7) ☐Patient Address (Section 1) ☐Administering Provider Address (Section 21) ☐Other Address (Fill out the required information below.)
Address*
City* | State* | ZIP Code*
Office Name* | Contact Phone*

9. Healthcare Provider Consent

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.

C 10. Healthcare Provider HIPAA and Telephone Consumer Protection Act (TCPA) Attestation

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.

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:

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For HCPs *(Page 5)*

Healthcare professionals should only complete Sections required for type of medication prescribed

For Oral Medications

A PAP HCP Consent

To be considered for PAP, the patient must have an FDA-approved diagnosis. Completion of this section is required if your patient is requesting assistance through PAP

B Prescription Information for Orals

Include strength and quantity for oral medication(s), and provide complete directions/dosing instructions

C Prescription Signature

Provide signature and date

D Preferred Specialty Pharmacy

Enter preferred Specialty Pharmacy for the patient, if known. If your patient doesn't know which Specialty Pharmacy their plan requires them to use (if applicable), your patient can request a benefit verification. Pfizer Oncology Together can assist you after completing a benefits verification with the payer

For Injectable Medications

E Administering Provider Information

Enter details about the HCP who is administering or overseeing product infusion if not the same in Section 7

Pfizer Oncology together™ **TO BE COMPLETED BY HCP** 5 OF 7

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11. Patient Information *Required fields

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

12. Diagnosis

Primary Diagnosis ICD-10* | Secondary Diagnosis ICD-10

A **13. 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.

HCP Signature* | **Date***

Complete for Oral Medications

B **14. Prescription Information for Orals** Required if prescribing oral products.

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

Directions/Dosing Instructions*:

Concomitant Medications*: | **Indicate number of refills*:**

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

Other Known Conditions*:

C **15. 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.

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.**

D **16. 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.

Complete for Injectable Medications

E **17. Administering Provider Information** (Administering/Overseeing Product Infusion) ☐ **Check if same as Section 7**

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

18. Dosing Information for Injectables* Required if prescribing Provider-administered injectable products.

†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 **1-877-736-6506** OR MAIL TO Pfizer Oncology Together, **PO Box 220366, Charlotte, NC 28222-0366**

As medications are added to the Pfizer Oncology Together portfolio and dosing/administration guidelines are updated, they are reflected on the Overview page and HCP sections of the enrollment form.

For HCPs *(Page 6)*

Healthcare professionals should only complete Sections required for type of medication prescribed

For Injectable Biosimilar Medications

A Diagnosis

If prescribing one of the Biosimilar medicines listed in Section 20, check the appropriate box and sign to confirm that patient does not have one of the listed conditions

B Administering Provider Information

Enter information about the HCP administering or overseeing product infusion if not the same in Section 7

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

Provide contact information and mailing address of practice billing office if different from the HCP/Site of Care Information or Administering Provider Information

D Prescription Information for Injectable Biosimilars

Provide dosing and directions for administration. This information is required if your patient is requesting PAP*

E Prescription Signature

Provide signature and date if your patient is requesting assistance through PAP*

Pfizer Oncology together™ **TO BE COMPLETED BY HCP** 6 OF 7

For questions, please 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.**

Complete for Injectable Biosimilar Medications

19. Patient Information *Required fields

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

A **20. 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: ____________

B **21. Administering Provider Information** (Administering/Overseeing Product Infusion) ☐ **Check if same as Section 7**

Name (First/MI/Last)* | Specialty*

NPI* | Group Tax ID* | State License* | DEA

Practice Name* | Office Contact*

Address*

City* | State* | ZIP Code*

Phone* | Fax* | Email*

C **22. 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 4 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*

D **23. Prescription Information for Injectables Biosimilars** **(Reimbursement Support and Co-Pay Only)**

Prescription Information for Injectables Biosimilars Required if requesting assistance through the Pfizer Patient Assistance Program†

Directions: | **Frequency:** | **Quantity:** | **Refills:**

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

Concomitant Medications*:

E **24. 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.

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.**

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