Pfizer Oncology together™

QUESTIONS? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

ENROLL ONLINE: Patients visit pfizeroncologypatientenroll.com and HCPs visit pfizeroncologytogether-portal.com (registration required).

Please complete and send pages 1-8 to Pfizer Oncology Together.

UPLOAD COMPLETED FORMS/DOCUMENTS VIA patientsupportnow.org Enter code: 8777366506

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

MAIL TO Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366

Patient Support Enrollment Form for Orals

☐ **New Uninsured or Government Underinsured Patient: Pfizer Patient Assistance Program (PAP)***

For patients who are uninsured or government underinsured and understand co-pay requirement but cannot afford co-pay and have been prescribed a medicine available through the PAP.

☐ **Requesting re-enrollment in the PAP**

Orals

- ☐ BOSULIF® (bosutinib)
- ☐ BRAFTOVI® (encorafenib)
- ☐ DAURISMO™ (glasdegib sodium)
- ☐ IBRANCE® (palbociclib)
- ☐ INLYTA® (axitinib)
- ☐ LORBRENA® (lorlatinib)
- ☐ MEKTOVI® (binimetinib)
- ☐ TALZENNA® (talazoparib)
- ☐ VIZIMPRO® (dacomitinib)
- ☐ XALKORI® (crizotinib)

Patient Eligibility for the Pfizer Patient Assistance Program

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

- Have a valid prescription for a Pfizer medicine available through the PAP
- Have an FDA approved diagnosis for the requested medicine(s) as confirmed by the HCP signing and dating **Section 13** of this form (if applicable)
- Have an annual household income at or below 300% of the Federal Poverty Level
- Reside in the U.S. or an applicable U.S. territory
- Be treated by a healthcare provider licensed in the U.S. or an applicable 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)

†Eligibility criteria are subject to change at any time.

IMPORTANT NOTE: Commercially insured patients are not eligible to enroll in the Pfizer Patient Assistance Program, even if the medication is not covered by the commercial insurance plan.

Enrollment Checklist for Patients

IMPORTANT NOTE: The patient must sign and date all applicable sections of the form unless they are incapacitated and unable to sign or they are under 18 years of age.

Patients/caregivers can complete, sign, and submit their portion of the Enrollment form online by visiting: pfizeroncologypatientenroll.com
OR complete this form using the following instructions:
Pages 1 through 5 should be completed by the patient or caregiver. When completing these pages, keep the following points in mind:

- Complete **Sections 1 and 2** ensuring that you include the Medicare Part D address if you have a Part D plan AND include copies of the front and back of all medical and pharmacy insurance cards.
- Sign and date **Section 3**.
- If applying for financial assistance:
  - Complete **Section 4** and either sign/date **Section 5** providing consent for electronic income verification OR you are required to submit proof of income documentation for your entire household (examples of acceptable documents in **Section 4**).
  - Sign and date **Section 6** and check the box if you want to sign up to receive PAP refill reminders and be able to request PAP refills via text message.
- All patients must sign and date the Patient Authorization to Share Health Information on **Page 5**.
- Patients must understand their insurer required co-pay prior to requesting assistance through the PAP.

Enrollment Checklist for HCP

HCPs can complete and submit Enrollment Forms online at pfizeroncologytogether-portal.com OR complete this form using the instructions below:
Pages 6 through 8 should be completed by the healthcare provider. Fill out every section for all patient enrollment requests and:

- Complete **Sections 7** (a Benefit Verification/Pharmacy Claim must be completed to determine the patient's insurance required co-payment before requesting assistance), **8**, and **9** (if the patient is applying for the PAP)
- Sign and date **Section 10**.
- Complete **Sections 11** and **12**.
- If your patient is applying for PAP, sign and date **Section 13** only if applicable to your patient.
- Complete the prescription in **Section 14** and sign and date **Section 15**.
- Complete **Section 16** if you patient has a preferred SP.
- Sign and date **Section 17** for all patients requesting 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.

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.

STOP **Patients/caregivers can complete, sign, and submit their portion of the Enrollment form online by visiting: pfizeroncologypatientenroll.com OR complete this form and submit using one of the methods below.**

Questions? 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.**

Please complete and send pages 1-8 to Pfizer Oncology Together.

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MAIL TO Pfizer Oncology Together, **PO Box 220366, Charlotte, NC 28222-0366**

HCP Information *Required fields

HCP Name (First/MI/Last)*	Contact Phone*

1 Patient Information

Patient 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.†

Is the Pfizer medication covered by either medical or prescription insurance?* ☐ Yes ☐ No

What is the co-pay amount?*
Your insurance-required co-pay amount must be known prior to requesting assistance.

	Primary Insurance	Secondary Insurance	Prescription Insurance
Check Insurance Type*: ☐ None (Skip to Section 4)	☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other	☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other	☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other
Insurance Name*			
Insurer's Phone*			
Policy/Medicare Beneficiary ID #*			
Group #*			
Policyholder Name*			
Relationship to Patient			
Policyholder DOB			
BIN #*			
PCN #*			

Medicare Part D Plan Address (if applicable), REQUIRED for PAP Enrollment*

Address		
City	State	ZIP Code

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

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3 Patient Consent to Receive Communications

This is required for all services. *Required fields

By signing and dating below, 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.

☐ Yes ☐ No

SIGN

Patient Signature* (Patient or patient representative must be 18 or older)	Patient representative name (please print)	**Date***

If signed/dated by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

4 Patient Financial Information

Required if requesting financial assistance services, including but not limited to the Pfizer Patient Assistance Program.† *Required fields

My provider or pharmacy has reviewed my insurer-required co-payment with me and I certify that I am unable to afford this. ☐ Yes ☐ No

Total Number of People Within Household (including applicant)*	Total Gross Annual Household Income* $

If you choose not to opt in for Electronic Income Verification in Section 4, you must submit documentation for household to support the financial information you've listed.
Attached is: ☐ Most recent federal tax return (IRS 1040 /1040-SR form) ☐ W-2 form ☐ Other

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

I, the applicant named 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 and dating 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 and date certifies that I have read and understand the above statements and agree to the outlined terms.

SIGN

Patient Signature* (Patient or patient representative must be 18 or older)	Patient representative name (please print)	**Date***

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

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Patients/caregivers can complete, sign, and submit their portion of the Enrollment form online by visiting: pfizeroncologypatientenroll.com OR complete this form and submit using one of the methods below.

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MAIL TO Pfizer Oncology Together, **PO Box 220366, Charlotte, NC 28222-0366**

6 Pfizer Patient Assistance Program† Certification, Attestation, and Privacy Disclosures

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 and dating 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 commercially insured patient, I cannot receive assistance through the Pfizer Patient Assistance Program even if my prescription is not covered by the commercial insurance plan. Any employer funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that I am a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan. **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.

Permission for Refill Reminder text communications:

☐ **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 (_____) _____-_____.

SIGN

Patient Signature* (Patient or patient representative must be 18 or older)	Patient representative name (please print)	**Date***

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

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

Pfizer Oncology together™

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.

- **To Patient: Read, sign, and date the Patient Authorization form. This is required to request assistance.**
- **To HCP: Send to Pfizer Oncology Together. Submit forms and documents via patientsupportnow.org. Enter code: 8777366506. Fax to: 1-877-736-6506 or Mail to: Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366.**

By signing and dating 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 my program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of my insurer's prior authorization requirements
  - Assisting with identification of my insurer's requirements for appealing a denied claim
- Determining my eligibility for and helping me access co-pay support or free drug programs
- 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 their 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 Oncology Together 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 Oncology Together at P.O. Box 220366, Charlotte, NC 28222-0366 or at 1-877-744-5675, 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 **Patient Signature** (Patient or patient representative must be 18 or older):

Patient representative name (please print):	Date:

If signed by patient representative, please indicate below the authority to act on behalf of patient:
☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

TO BE COMPLETED BY HCP

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7 Patient Information

*Required fields

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*
Is your patient's Pfizer medication you have been prescribed covered by either medical or prescription insurance?* ☐ Yes ☐ No **IMPORTANT NOTE:** If the patient is commercially insured, they are not eligible for assistance through the Pfizer Patient Assistance Program.	What is their co-pay amount?* $
Has your HCP office or a pharmacy completed a Benefit Investigation/ Pharmacy Claim for the requested product?* ☐ Yes ☐ No If NO, **Stop**. This is required to be completed prior to requesting PAP enrollment.	Does your patient understand their insured required co-pay and have they directly communicated that they are unable to afford this?* ☐ Yes ☐ No

8 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*

9 Shipping Information for Pfizer Patient Assistance Program† Patients

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

Patient Name*

Ship To*: ☐ Patient Address (Section 1) ☐ HCP/Site of Care Address (Section 8) ☐ Other Address (Fill out the required information below.)

Address*

City*	State*	ZIP Code*
Office Name*	Contact Phone*	

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

This is required for all services.

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.

By my signature and date, 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 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.

☐ Yes ☐ No

SIGN

HCP Signature* _____ **Date*** _____

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TO BE COMPLETED BY HCP

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11 Patient Information Required.

*Required fields

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

12 Diagnosis Required.

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

13 On-Label Certification This is required for PAP and, if not signed/dated, the patient is not eligible to be considered for the Pfizer Patient Assistance Program.

I certify that my decision to prescribe this Pfizer product is based solely on my independent clinical judgment, and I have prescribed the product for an FDA-approved indication consistent with all FDA requirements and labeling.

SIGN

HCP Signature* | Date*

14 Prescription Information for Orals Required.

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

- ☐ BOSULIF (bosutinib) _____ mg, 30-day supply ☐ Tablets ☐ Capsules
- ☐ BRAFTOVI (encorafenib) ☐ 300 mg, ☐ 450 mg, ☐ Other: _____ ☐ 30-day supply, ☐ Other: _____
- ☐ DAURISMO (glasdegib sodium) _____ mg, 30-day supply
- ☐ IBRANCE (palbociclib) _____ mg, 28-day supply
- ☐ INLYTA (axitinib) _____ mg, 30-day supply
- ☐ LORBRENA (lorlatinib) _____ mg, 30-day supply
- ☐ MEKTOVI (binimetinib) ☐ 45 mg, ☐ Other: _____ ☐ 30-day supply, ☐ Other: _____
- ☐ TALZENNA (talazoparib) _____ mg, 30-day supply Male HRR+: ☐ Yes ☐ No
- ☐ VIZIMPRO (dacomitinib) _____ mg, 30-day supply
- ☐ XALKORI (crizotinib) _____ mg, 30-day supply

Directions/Dosing Instructions*: | **Indicate number of refills*:**

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

Concomitant Medications*:

Other Known Conditions*:

15 Healthcare Provider Certification

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 (if received) to the appropriate pharmacy.

SIGN

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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16 Preferred Specialty Pharmacy

Preferred Specialty Pharmacy Name* ☐ Self-Dispensing Pharmacy

Preferred Specialty Pharmacy Address*

The patient identified on this form 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.

17 Pfizer Patient Assistance Program† Healthcare Provider Consent

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

The information you provide will be used by Pfizer to improve and tailor our products and services to better serve you. The information will also be used by the Pfizer Patient Assistance Foundation™ Inc. and parties acting on their behalf to administer and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs. By signing and dating below, you, the Prescriber, understand and agree to the following: I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable. Any medications supplied by Pfizer as a result of this enrollment form are for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement, nor will any cost related to it be applied toward the patient's true out-of-pocket costs (TrOOP). I certify that the information provided is current, complete, and accurate to the best of my knowledge. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I understand that commercially insured patients are not eligible for the Pfizer Patient Assistance Program, even if their prescription is not covered by the commercial insurance plan. Any employer funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that the patient is a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan. If the patient has Medicare Part D, Pfizer will notify the Medicare Part D Plan of their participation in the Pfizer Patient Assistance Program. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. Pfizer may contact the patient directly to confirm the receipt of medications. The information provided on this enrollment form is subject to random audits and verification. Pfizer may change or cancel this program at any time; Pfizer also reserves the right to terminate my patient's enrollment at any time. I will notify the Pfizer Patient Assistance Program immediately if the Pfizer product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes. I have a signed copy on file of my patient's current and completed Patient Authorization to Share Information Form so that I may share patient health information with the Pfizer Patient Assistance Program, Pfizer Inc., and the Pfizer Patient Assistance Foundation.™

SIGN

HCP Signature* **Date***

†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.

