Pfizer Oncology Together™ Co-Pay Savings Program for Injectables:
NIVESTYM™ (filgrastim-aafi) Injection Claim Form

Pfizer Oncology together™

The Pfizer Oncology Together Co-Pay Savings Program for Injectables for NIVESTYM provides eligible commercially insured patients with assistance of up to $10,000 per calendar year. Eligible enrolled patients may pay as little as $0 for each NIVESTYM treatment. Federal and state healthcare beneficiaries not eligible. Private insurance only. The co-pay program covers only drug costs, not procedures, administration fees, or office visits. Please see full Terms and Conditions below.

If there are any changes to the patient's provider, administering infusion provider, insurance, or contact information, call Pfizer Oncology Together at 877-744-5675 prior to the submission of the co-pay claim form.

Access Counselors are available Monday–Friday, 8 AM–8 PM ET.

Patients may be eligible for this offer if they:

- Have commercial insurance that covers NIVESTYM
- Are not enrolled in a state or federally funded insurance program

CLAIMS PROCESS

NOTE: *Patients must be enrolled in the Pfizer Oncology Together Co-Pay Savings Program for Injectables.*

Please submit the following:

1. A completed claim form within 120 days of the issue date shown on the patient's Explanation of Benefits (EOB)
2. A copy of the EOB (or dated pharmacy receipt if the prescription was filled by a pharmacy)
3. The group and member ID information on the Pfizer Oncology Together Co-Pay Savings Program for Injectables identification card (provided on the approval letter)

Submit via mail or fax:

Mail: Pfizer Oncology Together Co-Pay Savings Program for Injectables
P.O. Box 10751, Fairfield, NJ 07004

Fax: **1-833-307-2193**

Questions: **1-877-744-5675**

Pfizer Oncology Together Co-Pay Savings Program for Injectables | CLAIM FORM All fields marked with an asterisk (*) are required.

ADMINISTERING PROVIDER *(Enter the name of the administering provider or infusion center)*

PRACTICE NAME

*PROVIDER FIRST NAME

*PROVIDER LAST NAME

PATIENT

*PATIENT FIRST NAME

*PATIENT LAST NAME

PATIENT MIDDLE INITIAL

*GENDER ☐ Male ☐ Female

*ZIP CODE

*DATE OF BIRTH

*PATIENT GROUP NUMBER
(ie, EX00000000) (*from program ID card on the approval letter*)

*PATIENT MEMBER ID NUMBER
(*11-digit ID from program ID card on the approval letter*)

*DATE(S) OF SERVICE
(Provide date or date ranges)

*PATIENT OUT-OF-POCKET AMOUNT FOR NIVESTYM

UPDATED INSURANCE DETAIL *(if the insurance has changed since last submission)*

PRIMARY INSURANCE NAME

PRIMARY INSURANCE GROUP # FOR MEDICAL BENEFIT

PRIMARY INSURANCE ID FOR MEDICAL BENEFIT

PRIMARY INSURANCE BIN FOR PHARMACY BENEFIT

PRIMARY INSURANCE PCN FOR PHARMACY BENEFIT

PRIMARY INSURANCE GROUP # FOR PHARMACY BENEFIT

PRIMARY INSURANCE ID FOR PHARMACY BENEFIT

Terms and Conditions: By using this program, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions below:

The Pfizer Oncology Together Co-Pay Savings Program for Injectables for NIVESTYM is not valid for patients who are 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 assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud"). Program offer is not valid for cash-paying patients. With this program, eligible patients may pay as little as $0 co-pay per NIVESTYM treatment, subject to a maximum benefit of $10,000 per calendar year for out-of-pocket expenses for NIVESTYM including co-pays or coinsurances. The amount of any benefit is the difference between your co-pay and $0. After the maximum of $10,000 you will be responsible for the remaining monthly out-of-pocket costs. Patient must have private insurance with coverage of NIVESTYM. This offer is not valid when the entire cost of your prescription drug is eligible to be reimbursed by your private insurance plans or other private health or pharmacy benefit programs. You must deduct the value of this assistance from any reimbursement request submitted to your private insurance plan, either directly by you or on your behalf. You are responsible for reporting use of the program to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the program, as may be required. You should not use the program if your insurer or health plan prohibits use of manufacturer co-pay assistance programs. This program is not valid where prohibited by law. This program cannot be combined with any other savings, free trial or similar offer for the specified prescription. **This program is not health insurance.** This program is good only in the U.S. and Puerto Rico. This program is limited to 1 per person during this offering period and is not transferable. No other purchase is necessary. Data related to your redemption of the program assistance may be collected, analyzed, and shared with Pfizer, for market research and other purposes related to assessing Pfizer's programs. Data shared with Pfizer will be aggregated and de-identified; it will be combined with data related to other assistance redemptions and will not identify you. Pfizer reserves the right to rescind, revoke or amend this program without notice. This program may not be available to patients in all states. For more information about Pfizer, visit www.pfizer.com. For more information about the Pfizer Oncology Together Co-Pay Savings Program for Injectables, call 1-877-744-5675, or write to Pfizer Oncology Together Co-Pay Savings Program for Injectables, P.O. Box 220366, Charlotte, NC 28222. Program terms will expire at the end of each calendar year. Before the calendar year ends, you will receive information and eligibility requirements for continued participation.

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