Pfizer Oncology together™

Support Services & Patient Assistance Enrollment Form

Overview

The following form is used to enroll in Pfizer Oncology Together. Patients may also use the form to apply for the Pfizer Patient Assistance Program.* If you have questions, please call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

Pfizer Oncology Together Services For Patients

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

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of your insurer's prior authorization requirements
  - Assisting with identification of your insurer's requirements for appealing a denied claim
- Communicating with Healthcare Providers about a Pfizer medicine and Patient Support Activities
- Sending a device and starter kit (where appropriate)
- Provision of financial assistance resources and information, if eligible
- Determine eligibility for and helping with access to co-pay support or free drug programs (including the Pfizer Patient Assistance Program)
- One-on-one support 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

Pfizer Patient Assistance Program Eligibility Requirements

To qualify for free medicine, you must meet certain financial requirements, as well as meet the criteria below:

- Have a valid prescription for the Pfizer medicine for which they are seeking assistance
- Have no prescription coverage, or not enough coverage, to pay for their Pfizer medicine
- 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

Enrollment Checklist for Patients

Keep in mind:

- ☑ If seeking financial assistance, please include proof of income (such as page 1 of your tax return)
- ☑ Fax the front and back copy of your medical and pharmacy insurance cards
- ☑ Read the Privacy and HIPAA statements on pages 2, 4, & 5, and sign to provide your consent
- ☑ For personalized support, you may opt into Care Champion services and its text message program
- ☑ Patients accepted into the Pfizer Patient Assistance Program may opt into refill reminders via text messages

Enrollment Checklist for Healthcare Providers (HCPs)

Be sure to:

- ☑ Specify the Diagnosis in section 9
- ☑ Provide complete Directions/Dosing Instructions in section 10
- ☑ Read the Privacy and Consent statements on page 4 (section 12B) and sign 12A on page 3 to agree

Oral Therapy

- ☐ AROMASIN® (exemestane)
- ☐ BOSULIF® (bosutinib)
- ☐ DAURISMO™ (glasdegib)
- ☐ EMCYT® (estramustine phosphate)
- ☐ IBRANCE® (palbociclib)
- ☐ INLYTA® (axitinib)
- ☐ LORBRENA® (lorlatinib)
- ☐ SUTENT® (sunitinib malate)
- ☐ TALZENNA® (talazoparib)
- ☐ VIZIMPRO® (dacomitinib)
- ☐ XALKORI® (crizotinib)

Intravenous Therapy

- ☐ BESPONSA™ (inotuzumab ozogamicin)
- ☐ CAMPTOSAR® (irinotecan)
- ☐ ELLENCE® (epirubicin)
- ☐ IDAMYCIN® (idarubicin)
- ☐ MYLOTARG™ (gemtuzumab ozogamicin)
- ☐ TORISEL® (temsirolimus)
- ☐ ZINECARD® (dexrazoxane)

Your Color Coding Guide

Color coding indicates which sections of the form should be filled out by the **patient** or your healthcare provider **(HCP)**

PATIENT SECTION

HCP SECTION

The Pfizer Patient Assistance Program is a joint program of Pfizer Inc., and the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc., with distinct legal restrictions.

*Before submitting for the Pfizer Patient Assistance Program, be sure to fully use all co-payment assistance options available to you.

Pfizer Oncology together™

TO BE COMPLETED BY PATIENT

FAX THIS **COMPLETED** FORM TO 1-877-736-6506 or mail to Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366. If you have questions, please call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET

PATIENT SECTION

***Required fields**

1. Patient Information

Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*	Sex* ☐ Male ☐ Female
Street Address*	City*	
State* / ZIP Code*	Email Address	
Primary Phone #* ☐ Home ☐ Mobile ☐ Work	Secondary Phone # ☐ Home ☐ Mobile ☐ Work	
Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening	Preferred Language (if not English)	
Caregiver Name	Caregiver Phone # ☐ Home ☐ Mobile ☐ Work	

Patient Authorizations: ☐ I give permission to Pfizer Oncology Together to contact and leave messages for me about patient services and enrollment status. ☐ I give permission to Pfizer Oncology Together to communicate directly with my caregiver on my behalf.

2. Insurance Information: *Please include a copy of the front and back of your insurance card(s).*

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

Primary Insurance*	Policy/Medicare Beneficiary ID #*	GRP ID #*
Policyholder SSN	Insurer's Phone #	
Policyholder same as patient? ☐ Yes ☐ No	Policyholder Name*	
Relationship to Patient	Policyholder DOB (mm/dd/yyyy)	
Secondary Insurance	Policy/Medicare Beneficiary ID #	GRP ID #
Policyholder SSN	Insurer's Phone #	
Policyholder same as patient? ☐ Yes ☐ No	Policyholder Name*	
Relationship to Patient	Policyholder DOB (mm/dd/yyyy)	

Is the Pfizer medication covered? ☐ Yes ☐ No ☐ I don't know If yes, what is the co-pay amount? $_____ ☐ I don't know

Prescription Insurance*		Prescription Policy ID #*
Prescription BIN*	Prescription PCN*	Prescription GRP ID #*

3. Patient Financial Information (This information is required to find alternate funding support and verify eligibility for the Pfizer Patient Assistance Program,† as appropriate.)

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

Please submit documentation to support the financial information you've listed. Attached is: ☐ Most recent federal tax return ☐ W-2 form ☐ Other

4. Personalized Patient Support Opt in (Optional)

Personalized patient support is offered through Pfizer Oncology Together via Care Champions. You can speak with Care Champions 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. Care Champions 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 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.

5. Refill Reminders via Text Message (Optional for Pfizer Patient Assistance Program)

☐ Text me about my refills! By checking this box, I consent to receive refill reminder 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

6A. Patient Privacy and Consent (By signing below, I certify and acknowledge that I have read, understand, and agree to Patient Privacy and Consent Section 6B on page 4.)

Patient Signature* Patient or Personal Representative of Patient (If personal representative, indicate authority to sign on behalf of Patient).	**Date***

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc., and the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc., with distinct legal restrictions.

Pfizer Oncology together™

TO BE COMPLETED BY HCP

FAX THIS **COMPLETED** FORM TO 1-877-736-6506 or mail to Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366. If you have questions, please call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET

HCP SECTION

***Required fields**

7. HCP/Site of Care Information

HCP Name (First/MI/Last)*		Specialty*	Professional Designation
Practice/Institution Name*	Address*		
City*		State*	ZIP Code*
NPI*	State License	Group Tax ID*	DEA
Fax*	Email	Preferred Specialty Pharmacy	
Site of Care Location* ☐ Provider's office ☐ Hospital outpatient ☐ Hospital inpatient ☐ Other ☐ N/A			
Contact Name*		Contact Phone #*	

8. Administering Provider Information (Administering and oversees the product infusion) ☐ Check if same as above

Ship to* ☐ HCP ☐ Patient ☐ Site of Care ☐ Self-Dispensing Pharmacy		Patient Name*	
Name (First/MI/Last)*			Specialty*
NPI*	Tax ID*	State License*	
Practice Name*		Office Contact*	
Address*			
City*		State*	ZIP Code*
Office Phone #*	Fax	Email*	

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.

9. Diagnosis

Primary Diagnosis ICD-10*	Secondary Diagnosis ICD-10

10. Prescription Information (Required if prescribing oral products.)

Patient Name (First/MI/Last)*	Patient DOB*

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

☐ AROMASIN® (exemestane) 25 mg, 90-day supply	☐ LORBRENA® (lorlatinib) _____ mg, 30-day supply
☐ BOSULIF® (bosutinib) _____ mg, 30-day supply	☐ SUTENT® (sunitinib malate) _____ mg, ☐ 28-day supply ☐ 42-day supply
☐ DAURISMO™ (glasdegib) _____ mg, 30-day supply	☐ TALZENNA® (talazoparib) _____ mg, 30-day supply
☐ EMCYT® (estramustine phosphate) 140 mg, 90-day supply	☐ VIZIMPRO® (dacomitinib) _____ mg, 30-day supply
☐ IBRANCE® (palbociclib) _____ mg, 28-day supply	☐ XALKORI® (crizotinib) _____ mg, 30-day supply
☐ INLYTA® (axitinib) _____ mg, 30-day supply	

Directions/Dosing Instructions*:	**Indicate number of refills***
Concomitant Medications*:	**Please Note:** When e-prescribing, if you cannot find AmeriPharm (NPI number–1073692745, NCPDP number–4351968), you can also search for MedVantx under retail pharmacies (NPI number–1235371535; NCPDP number–44354180). The prescription will be sent to the same place.
Drug Allergies* ☐ No ☐ Yes (If yes, please list medication[s] and associated reaction[s]):	
Other Known Conditions*:	

11. Dosing Information for Physician Administered (IV) Products* (Required if prescribing IV products.)

☐ BESPONSA™ (inotuzumab ozogamicin)	Vial Size	# of Vials	☐ MYLOTARG™ (gemtuzumab ozogamicin)	Vial Size	# of Vials
☐ CAMPTOSAR® (irinotecan)	Vial Size	# of Vials	☐ TORISEL® (temsirolimus)	Vial Size	# of Vials
☐ ELLENCE® (epirubicin)	Vial Size	# of Vials	☐ ZINECARD® (dexrazoxane)	Vial Size	# of Vials
☐ IDAMYCIN® (idarubicin)	Vial Size	# of Vials			
Treatment start date			Frequency of treatment*		

12A. HCP Privacy and Consent (By signing below, I certify and acknowledge that I have read, understand, and agree to the prescription, privacy, and consent Section 12B on the following page.)

HCP Signature* NO STAMPS	_____ **Dispense As Written**	_____ **Substitution Allowed**	**Date***

Special Note: In addition to completing this section, New York prescribers must submit a prescription on an original NY state prescription blank. Prescribers in all other states only need to submit a state-specific blank if it's required in their state, and the application is mailed.

Pfizer Oncology together™

PROGRAM INFORMATION & CONSENT

FAX THIS **COMPLETED** FORM TO 1-877-736-6506 or mail to Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366. If you have questions, please call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET

PATIENT SECTION

HCP SECTION

6B. Patient Privacy and Consent: To be reviewed by the patient. (Read statement and sign Section 6A on page 2.)

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 support (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.

Consent to Receive Communications

By signing this form, I agree to 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.

Pfizer Patient Assistance Program Certification and Attestation

By signing the form, 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 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 HIPAA Authorization Form 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.

12B. HCP Privacy and Consent: To be reviewed by the Healthcare Provider. (Read statement and sign Section 12A on previous page.)

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.

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/or parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Pfizer, Pfizer Oncology Together, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

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. 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.

Pfizer Oncology together™

HIPAA AUTHORIZATION FORM FOR THE DISCLOSURE OF PATIENT INFORMATION BY PERSONAL PHYSICIAN

DO NOT FAX THIS HIPAA AUTHORIZATION FORM—IT IS FOR PATIENT AND HCP RECORDS ONLY. PLEASE RETURN THE SIGNED AUTHORIZATION TO YOUR DOCTOR. YOU ARE ENTITLED TO A COPY FOR YOUR RECORDS.

To Physician

Please retain the original signed Authorization with the patient's records and provide a copy to the patient. You do not need to return this patient Authorization to Pfizer.

To Patient

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Pfizer Inc., the Pfizer Patient Assistance Foundation, Pfizer affiliates and its vendors (collectively, "Pfizer"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Pfizer so that Pfizer may provide me with various support and information to help me access a Pfizer medicine, which may include the following, depending on your program ("collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with prior authorization requirements from my insurer
  - Assistance with appealing any denial from my insurer
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Sending me a device and starter kit (where appropriate)
- Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities
- Providing me with financial assistance resources and information if I'm eligible
- Providing me with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve our operations and services.

I understand that I do not have to sign this form, and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, the Pfizer 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. However, Pfizer agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me.

I understand that this form will remain in effect for 4 years from the date of my signature unless I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact the Pfizer Oncology Together at P.O. Box 220366, Charlotte, NC 28222-0366 and call 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 may receive a copy of this form.

I also give my permission to receive communications from Pfizer, the Pfizer Oncology Together, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as 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, 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	Date
Patient or Personal Representative of Patient (If representative, indicate authority to sign on behalf of patient.)	
Name (please print)	

