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.

Pfizer Oncology Together Services

- **Access & Reimbursement Support**
  Support to help patients get their medication
- **Patient Financial Assistance**
  Help connecting patients with financial support resources (including the Pfizer Patient Assistance Program)
- **Personalized Patient Support**
  One-on-one support to help address day-to-day needs (opt-in required)

Pfizer Patient Assistance Program Eligibility Requirements

To qualify for free medicine, you must:

- Have been prescribed one of the Pfizer medicines listed to the right
- Live in the United States or a US territory
- Have no prescription coverage or not enough coverage to pay for your Pfizer medicine
- Meet certain income limits (income limits vary by product and household size)

Enrollment Checklist for Patients

Remember to:

- ☑ Fill out all of the patient section of the enrollment form (page 2)
- ☑ Fill out the financial information in Section 3 and attach documentation of your total annual income (if seeking financial assistance)
- ☑ Fax a front and back copy of insurance and prescription card(s)
- ☑ Be sure to sign and date the Patient Privacy and Consent section
- ☑ Sign the HIPAA authorization and give it to your doctor
- ☑ Make a photocopy of your enrollment form, as it will not be returned to you
- ☑ Ask your doctor to complete, sign and submit the HCP section

Enrollment Checklist for Healthcare Providers (HCPs)

Be sure to:

- ☑ Fill out and sign the HCP section of the enrollment form (page 3)
  - Review the Prescription Information/HCP Privacy and Consent section
- ☑ Instruct the patient to review and sign the HIPAA authorization form
  - Retain the original signed form with the patient's records and provide a copy to the patient
- ☑ Fax the completed enrollment form to 1-877-736-6506

- ☐ AROMASIN® (exemestane)
- ☐ BESPONSA™ (inotuzumab ozogamicin)
- ☐ BOSULIF® (bosutinib)
- ☐ CAMPTOSAR® (irinotecan)
- ☐ ELLENCE® (epirubicin)
- ☐ EMCYT® (estramustine phosphate)
- ☐ IBRANCE® (palbociclib)
- ☐ IDAMYCIN® (idarubicin)
- ☐ INLYTA® (axitinib)
- ☐ MYLOTARG™ (gemtuzumab ozogamicin)
- ☐ SUTENT® (sunitinib malate)
- ☐ TORISEL® (temsirolimus)
- ☐ XALKORI® (crizotinib)
- ☐ ZINECARD® (dexrazoxane)

Your Color Coding Guide

Color coding indicates which sections of the form should be filled out by **you** 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.

IF YOU HAVE QUESTIONS, PLEASE CALL

1-877-744-5675

MONDAY–FRIDAY, 8 AM–8 PM ET

Pfizer Oncology together™

ENROLLMENT FORM: 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 fax a front and back copy of insurance and prescription card(s).*

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

Primary Insurance*	Policy ID #*	GRP ID #*
Policyholder SSN	Insurer's Phone #	
Policyholder same as patient? ☐ Yes ☐ No	Relationship to Patient	
Policyholder Name*	Policyholder DOB (mm/dd/yyyy) _____	
Secondary Insurance*	Policy ID #*	GRP ID #*
Policyholder SSN	Insurer's Phone #	
Policyholder same as patient? ☐ Yes ☐ No	Relationship to Patient	
Policyholder Name	Policyholder DOB (mm/dd/yyyy) _____	
Prescription Insurance*	Prescription Policy ID #*	
BIN* / PCN*	Prescription GRP ID #*	
Is the Pfizer medication covered? ☐ Yes ☐ No ☐ I don't know	If yes, what is the co-pay amount? _____ ☐ I don't know	

3. Patient Financial Information (This information is required to find alternate funding support and verify eligibility for patient assistance.)

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

4A. Intravenous (IV) Co-pay Program (Please review Section 4B on page 4 for program information.)

Complete only if you have been prescribed BESPONSA™ or MYLOTARG™ and have commercial insurance. This program is not available to patients with government insurance (Medicare, Medicaid, TRICARE, VA).

☐ By checking this box, I am applying for enrollment into the Pfizer Oncology Together Co-Pay Program for IV ("IV Co-Pay Program") and acknowledge the Terms and Conditions at PfizerOncologyTogether.com.

☐ **Assignment of Benefit:** By checking this box, and filling out the information to the right, I authorize the IV Co-Pay Program to transmit payment for certain out-of-pocket drug expenses for Product directly to my healthcare provider or specialty pharmacy. Please include the billing contact name and address where reimbursement will be sent below.

Billing Contact Name*		
Billing Address*		
City*	State*	ZIP Code*
Billing Phone*	Billing Email*	

5. 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 for this program, please check the box below.

☐ By checking this box, I request Care Champion support and agree to receive autodialed calls with offerings such as those described above from Pfizer Oncology Together and parties acting on its behalf, at the phone numbers provided on this form. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services.

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***

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ENROLLMENT FORM: HCP

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HCP SECTION

*Required fields

7. HCP/Site of Care Information

HCP Name (First/MI/Last)*			Professional Designation
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. Shipping Information required for all products, whether shipped to patient, HCP, or site of care. ☐ Check if same as above

Ship to* ☐ HCP ☐ Patient ☐ Site of Care		Patient Name*	
Shipping Contact*		Contact Phone #*	
Shipping Address*			
City*		State*	ZIP Code*

9. Diagnosis and Treatment History

Primary Diagnosis ICD-10*		Secondary Diagnosis ICD-10	
Current/Prior Medication(s) for Diagnosis*	Treatment Length (mm/yyyy)	Current/Prior Medication(s) for Diagnosis*	Treatment Length (mm/yyyy)
	_____ – _____		_____ – _____
	_____ – _____		_____ – _____

10. Prescription Information (Required for patients applying for patient assistance. For oral medications only.)

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	☐ INLYTA® (axitinib) _____ mg, 30-day supply
☐ BOSULIF® (bosutinib) _____ mg, 30-day supply	☐ SUTENT® (sunitinib malate) _____ mg, ☐ 28-day supply ☐ 42-day supply
☐ EMCYT® (estramustine phosphate) 140 mg, 90-day supply	☐ XALKORI® (crizotinib) _____ mg, 30-day supply
☐ IBRANCE® (palbociclib) _____ mg, 28-day supply	
Directions/Dosing Instructions*:	
Check One ☐ Dispense as Written ☐ May Substitute **Indicate number of refills***	
Concomitant Medications*:	
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 only.)

☐ 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*	**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.

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PROGRAM INFORMATION & CONSENT

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PATIENT SECTION

HCP SECTION

4B. Intravenous (IV) Co-pay Program (If you have been prescribed BESPONSA™ or MYLOTARG™ (Product) please complete Section 4A on page 2 after reviewing this information.)

For patients to be eligible for benefits under the IV Co-Pay Program, they must have commercial insurance that covers Product and they cannot be enrolled in a state or federally funded insurance program. IV Co-Pay Program provides assistance for eligible, commercially insured patients for co-pays, co-insurance, or deductibles incurred for Product, up to $25,000 per calendar year. It does not cover or provide support for supplies, services, procedures, or any other physician-related services associated with Product treatment. Whether a co-pay expense is eligible for the IV Co-Pay Program benefit will be determined at the time the benefit is paid. Co-pay expenses must be in connection with a separately paid claim for Product administered in the outpatient setting. Limits, terms, and conditions apply. Please see the IV Co-Pay Program's full Terms and Conditions at PfizerOncologyTogether.com.

6B. Patient Privacy And Consent (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. If applying to the Pfizer Oncology Together Co-Pay Program for IV, Assignment of Benefit will be granted to my provider or specialty pharmacy, if the appropriate box has been checked.

Permissions:
By signing the form, I agree to communications from Pfizer Oncology Together, Pfizer, or parties acting on their behalf about marketing topics and other resources and support that may be available. I also consent to receive autodialed non-marketing calls from Pfizer Oncology Together, Pfizer, or parties acting on their behalf. I represent that I am the account holder for the telephone number(s) I provided. I am responsible for notifying Pfizer Inc. immediately if I change my telephone number and may notify Pfizer Inc. of a number change by contacting Pfizer Oncology Together.

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 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. 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.

12B. HCP Privacy And Consent (Read statement and sign Section 12A on previous page.)

By signing this form, I certify that therapy with the selected medicine is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current Prescribing Information for the selected medicine. I will notify Pfizer 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 HIPAA Authorization Form so that I may share patient health information with Pfizer's Assistance Programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation, Inc. Pfizer and/or its agents may use such information as necessary to provide reimbursement support on behalf of your patient for certain Pfizer products including services such as benefit verification, prior authorization, and appeals support.

I also give my permission to receive calls related to these services from Pfizer Oncology Together, Pfizer, Pfizer Patient Assistance Foundation, Inc., and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided. I further authorize such parties to forward this form to a pharmacy based upon patient request and (as applicable) to assess my patient's eligibility for patient assistance.

By signing Section 12A, you, the Prescriber, understand and agree to the following:

- 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 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.

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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

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

Pfizer Inc. and the Pfizer Patient Assistance Foundation, Inc. offer various patient assistance programs (the "Programs") to help patients who qualify obtain certain Pfizer medicines at no cost and obtain reimbursement support services and co-pay cards. In order to determine your eligibility for the Programs and to administer your participation in the Programs if you are accepted, Pfizer, along with its affiliated companies and contractors who administer the Programs, need to obtain certain information about you from your physician (who is also called your "Doctor" in this form). **Please complete this Authorization, sign and date it, and return it to your doctor.**

I request and authorize my Doctor, _____, to give Pfizer Inc., including representatives and contractors who work on behalf of Pfizer in these Programs, and including service providers (collectively, "Pfizer"), my protected health information, including but not limited to information about my medical condition and treatments, which is necessary to determine my eligibility for the Programs and for my continuing participation in the Programs if I am accepted, to administer the Programs, to account for my withdrawal if I decide to stop participating in the Programs, and to evaluate patient satisfaction and the Programs' overall effectiveness. The type of information that can be given under this Authorization may include: my name and birth date, my address and telephone number, my Social Security number, financial information about me, information about my health benefits or health insurance coverage, and information on my medical condition, as necessary.

I understand that I may refuse to sign this Authorization and that it is strictly voluntary. Further, I understand that my Doctor may not condition the provision of my treatment on my signing this Authorization.

I understand that I can cancel (revoke) this Authorization at any time by writing to my Doctor at:

_____.

If I cancel this Authorization, then my Doctor will stop providing the information described above to Pfizer and its representatives for the purposes of the Programs. However, my cancellation will not affect actions that have already been taken in reliance on this Authorization.

I understand that once my Doctor gives Pfizer information about me based on this Authorization, federal or state privacy laws may not prevent Pfizer from further disclosing my information. I also understand that signing this Authorization does not guarantee that I will be accepted into a Pfizer Patient Assistance Program (the Programs).

Unless otherwise canceled, this Authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medicines under the Programs, whichever is later, or as required by state law.

Patient Signature	Date
Patient or Personal Representative of Patient (If representative, indicate authority to sign on behalf of Patient.)	
Name (please print)	

Please return the signed authorization to your Doctor. You are entitled to a copy for your records.

