PRESCRIPTION INFORMATION AND XELSOURCE ENROLLMENT FORM

For Use with Appropriate Rheumatoid Arthritis or Psoriatic Arthritis Patients Only

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.

Tips for completing the XELSOURCE Form

PAGE 1 – **PATIENT INFORMATION**

Have the patient fill out page 1 of the form, check off the appropriate box(es) in the Patient Authorization section, sign, and date. The patient's signature is needed for XELSOURCE to follow up with their pharmacy.

INSURANCE INFORMATION FOR PRESCRIPTION COVERAGE is a commonly missed section. Please make sure it's completed by the patient.

PAGE 2 – **HCP INFORMATION**

Complete all necessary fields on page 2. Please do not include any clinical notes as this may delay processing the form.

SPECIAL INSTRUCTIONS:

- **Benefits Investigation ONLY** – Pages 1 and 2 must be completed in their entirety, even if you are ONLY requesting a Benefits Investigation (BI). To avoid having to provide a new prescription upon BI completion, also complete Section 6 and XELSOURCE can move forward after a decision is made.
- **Voucher Program ONLY** – Sections 1, 3, 4, 6, and 7 must be completed, along with checking this box in Special Instructions, if you are only requesting a Voucher Program Rx for the new patient.*

PRESCRIBER INFORMATION and PRESCRIPTION INFORMATION are the most commonly missed sections. Please make sure they're completed before sending the form to XELSOURCE.

*Massachusetts residents may select their pharmacy. Otherwise, this free trial will be supplied through XELSOURCE. Vouchers and samples cannot be combined to support one single patient and are not intended to address financial hardship and insurance delays. See Terms and Conditions on page 4.

PAGES 1 AND 2 MUST BE RETURNED TO XELSOURCE.

PAGE 3 – **PATIENT AUTHORIZATION**

Have the patient review and sign the Patient Authorization form. Their signature is needed to document their HIPAA consent and for XELSOURCE to follow up with their pharmacy.

PAGE 4 – **XELSOURCE TERMS & CONDITIONS**

Please be sure to review the relevant terms and conditions to determine if the patient may be eligible for the Voucher Program† or Interim Care,† which can be selected in Section 6 of the form. You may give this page to the patient for reference.

†See limits, terms, and conditions on page 4.

By enrolling in XELSOURCE, patients will receive various support and information to help access XELJANZ/XELJANZ® XR (tofacitinib) extended release, 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 the patient's insurer's prior authorization requirements
  - Assisting with identification of the patient's insurer's requirements for appealing a denied claim
- Determining eligibility for and helping eligible patients access co-pay support or free drug programs
- Sending the patient a starter kit (where appropriate)
- Communicating with the patient's Healthcare Providers about XELJANZ/XELJANZ XR and Patient Support Activities
- Providing the patient with financial assistance resources and information, if eligible
- Providing the patient with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending the patient surveys about their experience with Pfizer products, services, and programs

Please complete and fax this form, along with a cover sheet, to 1-866-297-3471 or mail to XELSOURCE at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

For assistance call 1-844-935-5269

For enrollment into the Pfizer Patient Assistance Program, complete the Pfizer Patient Assistance Program Application available at www.xelsourceforms.com or by calling XELSOURCE

XELSOURCE℠
Answers and Support

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PATIENT INFORMATION

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For assistance or additional information, call
1-844-935-5269, Monday–Friday, 8 AM–8 PM ET

❶ PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____

DOB (mm/dd/yyyy) _____ Gender: ☐ M ☐ F

Address _____ City _____ State _____ ZIP Code _____

Primary Phone _____ ☐ H ☐ W ☐ M Alternate Phone _____ ☐ H ☐ W ☐ M

E-mail _____ Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening

Preferred Language (if not English) _____ U.S./Puerto Rico/Guam/U.S.V.I. Resident: ☐ Yes ☐ No

Caregiver Name _____ Caregiver Phone _____ ☐ H ☐ W ☐ M

❷ INSURANCE INFORMATION FOR PRESCRIPTION COVERAGE

Please attach copies of both sides of patient's insurance card(s). This section is not required for Voucher Rx only.

☐ **CHECK IF PATIENT DOES NOT HAVE PRESCRIPTION COVERAGE** ☐ **CHECK IF PATIENT HAS SECONDARY PRESCRIPTION COVERAGE**

Primary Insurance _____ Insurance Phone _____

Policy ID # _____ Group # _____

Policy Holder First Name _____ Policy Holder Last Name _____

Policy Holder DOB _____ Policy Holder Relationship to Patient _____

Prescription Drug Insurer _____ Phone _____

Policy ID # _____ Group # _____

Rx BIN # _____ Rx PCN # _____

Preferred Pharmacy _____ ☐ Self-Dispensing Pharmacy

Address _____ City _____ State _____ ZIP Code _____

The patient identified above prefers use of the pharmacy indicated above. I authorize Pfizer and its affiliates, agents, representatives and service providers to fax this prescription to the pharmacy designated above, provided it is approved by this patient's plan. If the pharmacy designated is not a plan-approved pharmacy, then to a pharmacy approved by this patient's plan. If there is no preferred pharmacy indicated, then to any pharmacy approved by this patient's plan.

❸ PATIENT AUTHORIZATION to receive communications.

By signing this form, I agree to communications from Pfizer, XELSOURCE, 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, XELSOURCE, or parties working on their behalf for these purposes using email, text message, a live operator, 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, XELSOURCE, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, XELSOURCE, 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 XELSOURCE at 1-844-935-5269.

☐ I certify that I am not a resident of any of the following states: MA, MI, MN, MO, OH, RI.

☐ By checking this box and providing my cellular number, I consent to receive enrollment status, prescription updates, and refill reminders from XELSOURCE via text message. I will receive a welcome text asking me to reply YES to opt-in. Message and data rates may apply; number of messages varies based on program use, but is up to 10 texts per month. Reply STOP to cancel. Privacy policy available at www.pfizer.com/privacy and full Terms and Conditions available at https://m.enrollsource.com/pfe.

Please enter the number you would like to enroll for texting _____

_____ _____

Patient Name Date

X _____ _____

Signature: Patient/Certification of person legally authorized to sign for patient Relationship

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HCP 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.

Please complete and fax this form, along with a cover sheet, to 1-866-297-3471 or mail to XELSOURCE at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

For assistance or additional information, call 1-844-935-5269, Monday–Friday, 8 AM–8 PM ET

SPECIAL INSTRUCTIONS Check all that apply based on the patient's needs.

☐ **Voucher Program ONLY** ☐ **Benefits Investigation ONLY** ☐ XELJANZ® (tofacitinib) 5 mg ☐ XELJANZ® XR (tofacitinib) 11 mg extended release

Patient Full Name _____ Patient DOB (mm/dd/yyyy) _____

❹ PRESCRIBER INFORMATION

Prescriber First Name _____ Prescriber Last Name _____ Specialty _____

Prescriber NPI # _____ Group Tax ID # _____ State License # _____

Practice Name _____ Office Contact _____

Address _____ City _____ State _____ ZIP Code _____

E-mail _____ Phone _____ Fax _____

❺ CLINICAL INFORMATION This section is not required for Voucher Rx only.

DO NOT ATTACH ANY CLINICAL OR OFFICE NOTES AS THIS MAY DELAY PROCESSING THE FORM

☐ Rheumatoid arthritis with rheumatoid factor: **M05.** _____ (Complete the ICD-10-CM code)

☐ Other rheumatoid arthritis: **M06.** _____ (Complete the ICD-10-CM code)

☐ Arthropathic psoriasis, unspecified: **L40.50**

☐ Distal interphalangeal psoriatic arthropathy: **L40.51**

☐ Psoriatic arthritis mutilans: **L40.52**

☐ Psoriatic spondylitis: **L40.53**

☐ Other psoriatic arthropathy: **L40.59**

❻ PRESCRIPTION INFORMATION Be sure to check the appropriate Rx, fill in # of refills, and sign below in section 7.

Prescription for XELJANZ tablets

☐ 5 mg PO BID, Quantity #60

☐ 11 mg XR PO QD, Quantity #30

Refills #: _____

Free XELJANZ Rx Offers: Only filled through Sonexus Health Pharmacy Services. See page 4 for limits, terms, and conditions.

Voucher Program (NO Refills):

☐ 5 mg PO BID (up to 30 days, 60 tablets)

☐ 11 mg XR PO QD (up to 30 days, 30 tablets)

Patients new to XELJANZ only. MA residents may select their pharmacy. Otherwise, this free trial will be supplied through Sonexus Health Pharmacy Services.

Interim Care Rx (11 Refills):

☐ 5 mg PO BID (up to 30 days, 60 tablets)

☐ 11 mg XR PO QD (up to 30 days, 30 tablets)

If eligible, treatment may be provided at no cost if a delay occurs in the coverage determination process. For commercially insured patients only (not available for Medicare, Medicaid, or other federal or state healthcare programs or in MA, MI, MN, MO, OH, RI).

❼ HEALTHCARE PROVIDER HIPAA CONSENT AND ATTESTATION

Prescriber Signature (MANDATORY)

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 XELJANZ/XELJANZ XR.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, XELSOURCE, 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, XELSOURCE, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

X _____ _____ X _____ _____

Doctor/Prescriber Signature: NO STAMPS **(Dispense as Written)** Date Doctor/Prescriber Signature: NO STAMPS **(Substitution Allowed)** Date

If you are a New York prescriber, please use an original New York State prescription form.

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

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Answers and Support

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 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
- Sending the patient a 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, XELSOURCE 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 XELSOURCE at 1-844-935-5269 or 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067. 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, XELSOURCE, 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, XELSOURCE, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, XELSOURCE, 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 XELSOURCE at 1-844-935-5269.

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X_____ _____

Signature of Patient Date

TERMS & CONDITIONS

XELSOURCE℠
Answers and Support

VOUCHER TERMS AND CONDITIONS

By redeeming this voucher, you acknowledge that you currently meet the eligibility criteria and will comply with the terms & conditions described below:

You will receive a one-time 30-day supply of XELJANZ® (tofacitinib)/XELJANZ® XR (tofacitinib) extended release. Only new patients may use this voucher. By redeeming this voucher, you certify that you are not currently using XELJANZ/XELJANZ XR. An original voucher and a valid prescription must be presented to the pharmacy. **The voucher will be accepted only at participating pharmacies.* You must not submit any claim for reimbursement for product dispensed pursuant to this voucher to any third-party payor, including Medicare, Medicaid, or any other federal or state health care program. You cannot apply the value of the free product received through this voucher toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).** You must be 18 years of age or older to redeem this voucher. This voucher is not valid where prohibited by law. This voucher cannot be combined with any other savings, free trial, or similar offer for the specified prescription. **This free trial voucher is not health insurance.** This voucher should not be combined with samples for the specified prescription. This free trial voucher is not intended to address delays or gaps in health insurance coverage for the specified prescription. Offer good only in the U.S. and Puerto Rico. No purchase is necessary. Patients have no obligation to continue to use XELJANZ/XELJANZ XR. Pfizer reserves the right to rescind, revoke, or amend this offer without notice. This voucher expires 12/31/2021.

*MA residents may select their pharmacy. Otherwise, this free trial will be supplied through XELSOURCE.

INTERIM CARE RX PROGRAM TERMS & CONDITIONS

Interim Care Rx is not health insurance and is available for eligible, commercially insured patients only. Offer is only available to patients who have been diagnosed with an FDA-approved indication for XELJANZ/XELJANZ XR. No claim for reimbursement for product dispensed pursuant to this offer may be submitted to any third-party payer. Not available to patients covered under government plans such as Medicaid, Medicare or other federal or state healthcare programs, including any state prescription drug assistance programs and the Government Health Insurance Plan or for residents of Massachusetts, Michigan, Minnesota, Missouri, Ohio, or Rhode Island. Available up to a 30-day supply. Refills are subject to limitations. Interim Care Rx offer does not require, nor will be made contingent on, purchase requirements of any kind. Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification. Interim Care Rx can only be dispensed by the exclusive pharmacy and only after benefits investigation has been completed and a delay occurs in the prior authorization or appeals process. Offer good only in the U.S. and Puerto Rico. Prescription must be provided by a healthcare provider licensed in the U.S. or Puerto Rico. Continued eligibility for the program requires submission of two appeals within 180 days of enrollment. After 12 months of program enrollment, an updated prescription and benefits investigation is required to confirm continued eligibility. Additional eligibility criteria may apply. Contact XELSOURCE for details.

DISCLAIMER

Pfizer's program provider performing XELSOURCE support programs provides patient insurance benefit verification as a program under contract for Pfizer Inc. XELSOURCE support programs assist patients in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Many factors affect third-party reimbursement. Pfizer Inc. and Pfizer's program provider performing the XELSOURCE support programs make no representation or guarantee that insurance reimbursement or any other payment will be available. This information is provided as an information service only. While Pfizer's program provider performing XELSOURCE support programs tries to provide correct information, it and Pfizer Inc. make no representations or warranties, expressed or implied, as to the accuracy of the information. The support programs administrator, or Pfizer Inc., or its employees or agents shall in no event be liable for any damages resulting from or relating to the programs. Responsibility for the use of this program is agreed upon and accepted by all providers and other users of this information.

Pfizer Inc. does not guarantee, and assumes no responsibility for, the quality, scope, or availability of the XELSOURCE support programs including but not limited to reimbursement support programs, patient education, and other support programs. XELSOURCE support programs are included within the cost of the product, and have no independent value to providers apart from the product.