# PFIZER PATIENT ASSISTANCE PROGRAM*

Phone 1-844-935-5269 | Fax 1-866-297-3471 | 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067

XELSOURCE℠
Answers and Support

## PATIENT APPLICATION

**Please complete the form where applicable and return via mail or fax. Pages 1 and 2 must be returned to XELSOURCE.**

☐ **Check here if reapplying for the Pfizer Patient Assistance Program.**

| | | | |
|---|---|---|---|
| **PATIENT INFORMATION** | Name: | | |
| | Address: | | |
| | City: | State: | ZIP: |
| | Telephone (Day): | Telephone (Evening): | |
| | E-mail (Please provide to speed up process): | | |
| | Date of Birth (DOB): | | |
| **INSURANCE INFORMATION** | ☐ I confirm that I do not have prescription drug coverage. | | |
| **MEDICARE PART D INSURANCE MAILING ADDRESS** | Address: | | |
| | City: | State: | ZIP: |
| **PATIENT FINANCIAL INFORMATION** | **Total Number of People Within Household (including applicant):** _____<br>**Total Annual Income for Entire Household: $** _____<br>(The current annual household income includes current annual salary, Social Security, unemployment insurance benefits, and workers' compensation)<br>**Please submit documentation to support the financial information if you do not want your income to be verified electronically.**<br>**Attached is:** ☐ **Most recent federal tax return (1040 form)** ☐ **W-2 form** ☐ **Other**<br>We must receive proof of income to determine eligibility for assistance.<br>If you are required to file a federal tax return, please provide a signed copy. Proof of income may include documents such as: copy of most recent federal tax return, W-2 form(s), 1099 form, Social Security Award Letter or Check, or copies of three most recent pay stubs. | | |

**Patient Authorization for Electronic Income Verification** (Optional, but may reduce application review time)

I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Reporting Act authorizing Pfizer Inc. to obtain information from my credit profile or other information from Experian® Income View℠. I authorize Pfizer Inc. 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 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 for two (2) years from the date of the signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, but that this cancellation will not apply to any information already used or disclosed through this Authorization.

**Patient Authorization for Financial Screening:** My signature certifies that I have read and understand the above statements, and agree to the outlined terms.

X _____

**Patient Signature (Parent or Guardian, if under 18 years of age)** **Date**

**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 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.

**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 HIPAA Authorization 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.

*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.

X _____

**Patient Signature (Parent or Guardian, if under 18 years of age)** **Date**

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## HCP TO COMPLETE

**Please complete the form where applicable and return via mail or fax. Pages 1 and 2 must be returned to XELSOURCE.**

☐ **Check here if the patient is reapplying for the Pfizer Patient Assistance Program.**

| | | | | |
|---|---|---|---|---|
| **PRESCRIBER INFORMATION (To be completed by the provider)** | Name & Title: | | Specialty: | |
| | Payer Specific #: | NPI #: | Tax ID #: | |
| | State License #: | | DEA #: | |
| | Name of Facility: | | | |
| | Address: | | | |
| | City: | | State: | ZIP: |
| | Contact Name: | | | |
| | Contact Phone: | | Fax: | |
| | Contact E-mail Address: | | | |

| | | |
|---|---|---|
| **PRESCRIBER CERTIFICATION** | **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™ 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.**<br>**By signing 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 certify that my decision to prescribe a Pfizer product is based solely on my independent clinical judgment.** I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. 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 HIPAA Authorization Form so that I may share patient health information with the Pfizer Patient Assistance Program, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc. |
| | **Prescriber Signature** X | Date: |

| | | | |
|---|---|---|---|
| **SHIP TO** | ☐ Prescriber ☐ Patient ☐ Other (please provide shipping address—NO PHARMACIES): | | |
| | Address: | | |
| | City: | State: | ZIP: |

| | | | |
|---|---|---|---|
| **CLINICAL AND PRESCRIPTION INFORMATION** | Patient First Name: | Patient Last Name: | |
| | Patient Date of Birth: | Patient Phone: | |
| | Rx: ☐ XELJANZ 5 mg PO BID, 30-day supply ☐ XELJANZ 5 mg PO QD†, 30-day supply ☐ XELJANZ 10 mg PO BID, 30-day supply ☐ XELJANZ XR 11 mg PO QD, 30-day supply ☐ XELJANZ XR 22 mg PO QD, 30-day supply | | Refills (up to 11): |
| | Drug Allergies: ☐ Yes ☐ No If yes, please list medication(s) and associated reaction(s): | | |
| | | | |
| | Patient's current medication(s): | | |
| | **Prescribing Physician Signature**—NO STAMPS (Dispense as written) | | |
| | X | | Date: |

**Note: If you are a New York prescriber, please attach state prescription form.**

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†Recommended for patients with moderate to severe renal impairment or moderate hepatic impairment.

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## Patient Authorization to Share Health Information

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 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, 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.

Signature of Patient _____ Date _____