PRESCRIPTION INFORMATION AND XELSOURCE ENROLLMENT FORM

For Use with Appropriate Ulcerative Colitis Patients Only

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

By enrolling in XELSOURCE, patients will receive various support and information to help access XELJANZ® (tofacitinib), which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with prior authorization requirements from the patient's insurer
  - Assistance with appealing any denial from the patient's insurer
- 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 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

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.

XELSOURCE℠
Answers and Support

PRESCRIPTION INFORMATION AND XELSOURCE ENROLLMENT FORM

For Use with Appropriate Ulcerative Colitis Patients Only

PATIENT INFORMATION

XELSOURCE℠
Answers and Support

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

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).

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

Primary Insurance _____ Insurance Phone _____

Policy ID # _____ Group # _____

Policy Holder Name (First, Last), DOB, and Relationship to Patient _____

Prescription Drug Insurer _____ Patient's Preferred Pharmacy _____

Policy ID # _____ Group # _____

Rx BIN # _____ Rx PCN # _____

Preferred Specialty Pharmacy _____ ☐ Self-Dispensing Pharmacy

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.

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 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, 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.

☐ I give permission for XELSOURCE to send me e-mail communications regarding XELSOURCE.

☐ 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 on page 5.

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

PRESCRIPTION INFORMATION AND XELSOURCE ENROLLMENT FORM

For Use with Appropriate Ulcerative Colitis Patients Only

HCP INFORMATION

XELSOURCE℠
Answers and Support

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

BENEFITS INVESTIGATION ONLY

Check and sign below if you are ONLY requesting a summary of the patient's benefits. ☐ XELJANZ® (tofacitinib)

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

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

☐ Ulcerative colitis: **K51.** _____ (Complete the ICD-10-CM code)

☐ Other: _____ (Insert the ICD-10-CM code)

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

☐ 10 mg PO BID, Quantity #60

Refills #: _____

Free XELJANZ Rx Offers: Only filled through Sonexus Health Pharmacy Services.* See pages 5-6 for limits, terms, and conditions.

Voucher Program: ☐ 5 mg PO BID (up to 30 days, 60 tablets), NO refills ☐ 10 mg PO BID (up to 30 days, 60 tablets), NO refills

Interim Care Rx: ☐ 5 mg PO BID (up to 30 days, 60 tablets), 5 refills ☐ 10 mg PO BID (up to 30 days, 60 tablets), 5 refills

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).

*MA residents may select their pharmacy. Otherwise, this free trial will be supplied through Sonexus Health Pharmacy Services.

❼ HEALTHCARE PROVIDER HIPAA CONSENT AND ATTESTATION

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.

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

XELSOURCE℠
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 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 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.

X _____ _____

Signature of Patient Date

Clear Form Print Form

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). Only new patients may use this voucher. By redeeming this voucher, you certify that you are not currently using XELJANZ. 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, TRICARE, 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 for Massachusetts residents whose prescriptions are covered in whole or in part by third party insurance. 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.** Offer good only in the US and Puerto Rico. No purchase is necessary. Patients have no obligation to continue to use XELJANZ. Pfizer reserves the right to rescind, revoke, or amend this offer without notice. This voucher expires 12/31/2020.

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

XACCESS SMS PROGRAM TERMS & CONDITIONS

User texts XACCESS to short code 88396. Text HELP for help, STOP to opt out.

Users may receive up to 10 messages per month. Message and data rates may apply **1.** By opting into the XACCESS mobile texting program (Program), you consent to receive up to 10 text messages from Pfizer Inc. Such messages may be marketing or non-marketing messages and may include prescription related information, fill confirmation, refill reminders, website information, etc. T-Mobile is NOT liable for delayed or undelivered messages. **2. To stop receiving text messages, text STOP to 88396. DOING SO WILL ONLY OPT YOU OUT OF THIS PROGRAM; you will remain opted in to any other Pfizer Inc text message program(s) into which you opted separately. 3.** To request more information or to obtain help, text HELP to 88396. You can also call customer service at 1-844-935-5269. **4.** You represent that you are the account holder for the mobile telephone number(s) that you provide to opt into the Program. You are responsible for notifying Pfizer Inc immediately if you change your mobile telephone number. You may notify Pfizer Inc of a number change by calling 1-844-935-5269. **5.** Message and data rates may apply to each text message sent or received in connection with the texting program, as provided in your mobile telephone service rate plan (please contact your mobile telephone carrier for pricing plans). Applicable roaming charges may apply. Charges are both billed and payable to your mobile service provider or deducted from your prepaid account. Pfizer Inc does not impose a separate fee for sending text messages. **6.** Data obtained from you in connection with this Program may include your telephone number, your carrier's name, and details of the message (date, time, and content). Pfizer Inc may use this information to contact you and to provide the services you request. **7.** For information on data collection and use, please read our full corporate Privacy Policy (https://www.pfizer.com/Privacy), which is incorporated by reference into these Terms. **8.** Pfizer Inc will not be liable for any delays in the receipt of any SMS messages, as delivery is subject to effective transmission from your network operator. **9. This Program is available only on these US participating mobile carriers:** [AT&T, Verizon Wireless, Sprint, T-Mobile, U.S. Cellular, Boost Mobile, MetroPCS, Virgin Mobile, Alaska Communications Systems (ACS), Appalachian Wireless (EKN), Bluegrass Cellular, Cellular One of East Central, IL (ECIT), Cellular One of Northeast Pennsylvania, Cricket, Coral Wireless (Mobi PCS), COX, Cross, Element Mobile (Flat Wireless), Epic Touch (Elkhart Telephone), GCI, Golden State, Hawkeye (Chat Mobility), Hawkeye (NW Missouri), Illinois Valley Cellular, Inland Cellular, iWireless (Iowa Wireless), Keystone Wireless (Immix Wireless/PC Man), Mosaic (Consolidated or CTC Telecom), Nex-Tech Wireless, NTelos, Panhandle Communications, Pioneer, Plateau (Texas RSA 3 Ltd), Revol, RINA, Simmetry (TMP Corporation), Thumb Cellular, Union Wireless, United Wireless, Viaero Wireless, and West Central (WCC or 5 Star Wireless)]. **10.** You agree to indemnify Pfizer Inc and any third parties texting on its behalf in full for all claims, expenses, and damages related to or caused, in whole or in part, by your failure to immediately notify us if you change your telephone number, including but not limited to all claims, expenses, and damages related to or arising under the Telephone Consumer Protection Act. **11.** Pfizer Inc may immediately suspend or terminate your participation in the Program if it believes you are in breach of these SMS Terms and Conditions. Your participation in this Program is also subject to termination in the event that your mobile telephone service terminates or lapses. Pfizer Inc reserves the right to modify or discontinue, temporarily or permanently, all or any part of the Program, with or without notice. **12.** Pfizer Inc may revise, modify, or amend these SMS Terms and Conditions at any time. Any such revision, modification, or amendment shall take effect when it is posted to Pfizer Inc's website. You agree to review these SMS Terms and Conditions periodically to ensure that you are aware of any changes. Your continued consent to receive text messages will indicate your acceptance of those changes.

Call 1-844-935-5269, Monday through Friday, 8:00 AM–8:00 PM ET, for more information.

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. 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 US and Puerto Rico. Prescription must be provided by a healthcare provider licensed in the US or Puerto Rico. Additional eligibility criteria may apply. Contact XELSOURCE for details.

CO-PAY CARD TERMS AND CONDITIONS

By using the XELJANZ Co-pay Savings Card (the "Card"), you acknowledge that you currently meet the eligibility criteria and will comply with the following terms and conditions.

Patients are not eligible to use this card if they are enrolled in a state- or federally-funded insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veteran 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"). Patient must have private insurance. Offer is not valid for cash paying patients. You will receive a maximum benefit of $15,000 per calendar year, which is defined by the date of enrollment through December 31st of the enrollment year, and may pay as little as $0 per month co-pay. After a maximum of $15,000, you will be responsible for paying the remaining monthly out-of-pocket costs. This Card is not valid when the entire cost of your prescription drug is eligible to be reimbursed by your private insurance plan or other private health or pharmacy benefit programs. You must deduct the value of this coupon from any reimbursement request submitted to your insurance plan, either directly by you or on your behalf. You are responsible for reporting use of the Card to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the Card, as may be required. You should not use the Card if your insurer or health plan prohibits use of manufacturer Cards. You must be 18 years of age or older to redeem the Card. The Card is not valid where prohibited by law. The Card cannot be combined with any other savings, free trial, or similar offer for the specified prescription. **The Card will be accepted only at participating pharmacies. If your pharmacy does not participate, you may be able to submit a request for a rebate in connection with this offer. The Card is not health insurance.** Offer good only in the US and Puerto Rico. The Card is limited to 1 per person during this offering period and is not transferable. The Card may be used once per month for the life of the program. No other purchase is necessary. Data related to your redemption of the Card 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 Card redemptions and will not identify you. Pfizer reserves the right to rescind, revoke, or amend the program without notice. Card and Program expires 12/31/2019. If you have questions or are in need of additional support, call 1-844-935-5269 or visit www.XELJANZ.com.

PFIZER PATIENT ASSISTANCE PROGRAM* ELIGIBILITY CRITERIA

The Pfizer Patient Assistance Program is not health insurance and is available for eligible uninsured/underinsured patients only. Offer is only available to patients who meet financial and other criteria. This offer does not require, nor will it be made contingent on, purchase requirements of any kind. No claim for reimbursement or credit for any costs associated with the medicine(s) may be submitted to any prescription insurance provider or payer, including Medicare Part D plans. Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification. Offer good only in the US and Puerto Rico. Patient must be a resident of the United States or Puerto Rico. Prescription must be provided by a healthcare provider licensed in the US or Puerto Rico. Patient must be treated in the outpatient setting of care. Additional eligibility criteria may apply. Contact XELSOURCE for details.

*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.