Prescription and Patient Support Enrollment Form

PFIZER DERMATOLOGY patient access™

HCPs can go to PfizerDermatologyHCPPortal.com to complete this form online.
Questions? Call 1-833-956-3376, Monday–Friday, 8:00 AM to 8:00 PM ET.

HCPs can upload online at PfizerDermatologyHCPPortal.com | Fax completed forms to 1-877-548-1734 | HCPs can e-Prescribe directly to Sonexus Health Pharmacy Services*

SELECT PATIENT PRESCRIPTION (*Select ONE MEDICATION per enrollment form)	
CIBINQO® (abrocitinib) tablets ☐ 50 mg ☐ 100 mg ☐ 200 mg	LITFULO® (ritlecitinib) capsules ☐ 50 mg

FOR PATIENTS – Complete the following sections; then, read, sign, and date (where applicable) the required authorization and consents on pages 2 and 3. Missing information or consents may cause delays in filling your prescription and signing you up for the Pfizer Dermatology Patient Access™ support program.

1. PATIENT INFORMATION (*REQUIRED)

First Name* _____ MI _____ **Last Name*** _____

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

Address* _____ **City*** _____ **State*** _____ **ZIP Code*** _____

Primary Phone* _____ ☐ H ☐ W ☐ M

Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening

Email _____

Preferred Language (if not English) _____

Caregiver Name _____ Phone _____
(*Required if patient is under 18)

Consent to Receive Text Messages
By providing your phone number, you consent to receive communications from Pfizer with information regarding the Pfizer Dermatology Patient Access Program. You understand that providing this consent is not required or a condition of purchasing any products or services. Message frequency varies. Message and data rates may apply. Complete terms can be found at Engagedrx.com/PDPA and Pfizer's privacy policy at Pfizer.com/privacy. Text STOP to opt out of text messages.

2. INSURANCE INFORMATION - Insurance Type*: ☐ Commercial ☐ Government ☐ Medicare Part D ☐ Other ☐ None (*REQUIRED)

	Primary Medical Insurance*	Primary Prescription Insurance*	Secondary Prescription Insurance
	(*REQUIRED only if front and back copies of insurance card[s] are NOT provided)		
Policyholder Name*			
Insurance Name*			
Insurance Phone*			
Policy ID #*			
Group #*			
BIN #*			
PCN #*			

*If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying that you have received patient consent for Sonexus Health Pharmacy Services and Pfizer Dermatology Patient Access™ to contact your patient and provide them services. Sonexus Health Pharmacy Services is categorized as a mail-order pharmacy in EMR/EHR systems and is located at 2730 S Edmonds Lane, Suite 400, Lewisville, TX 75067.

Questions? Call 1-833-956-3376, Monday–Friday, 8:00 AM to 8:00 PM ET.

3. CONSENT TO COLLECT AND USE PERSONAL DATA (*REQUIRED)

Pfizer Inc. ("Pfizer") collects certain Personal Data (described below) about individuals so that it may provide patient support services to eligible patients through the Pfizer Dermatology Patient Access Program (the "Program"). Pfizer is seeking this consent because it needs to collect and use such data, which is considered sensitive data in some jurisdictions, in connection with operation of the Program.

Personal Data Collected and/or Used. The Personal Data Pfizer and its service providers may collect and use includes name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that you are seeking health care services, and data otherwise related to your health condition, diagnosis, and/or treatment (collectively "Personal Data").

Purposes of Collection and Use. Your Personal Data will be used for the following purposes:

Your Personal Data will be used by Pfizer who will provide patient support services to eligible patients including, where applicable, determining eligibility for copay support and free drug programs.

Duration. By signing this consent to collect and use, I agree that these entities may use the Personal Data to provide applicable patient support services or as permitted or required by applicable privacy laws. I permit such use for two years after the date I sign the consent, unless and until I revoke (i.e., take back) it in writing prior to that time.

Revocation. I may revoke my consent at any time, except to the extent that Pfizer has taken any action in reliance on my consent. I understand that if I revoke my consent, it will not have any effect on any collection, uses, or disclosures of my Personal Data that occurred prior to receiving my revocation. To revoke, I understand that I must notify Pfizer Dermatology Patient Access™ by emailing patientprivacy@sonexushealth.com or by calling 1-833-956-DERM (1-833-956-3376), 8 AM–8 PM M–F ET.

I understand that my consent to collect and use my Personal Data is voluntary and may be revoked in writing at any time.

I have read this consent and/or had its contents read to me. I fully understand the terms and conditions described above.

Consent to Collect Personal Data:
By signing and dating below, I consent on my own free will and I agree to the collection and use of my Personal Data as described above. I understand that a signed copy of this consent is available to me upon request.

SIGN X _____ _____ _____

Patient Signature* (Patient or patient representative must be 18 years or older)† | Patient or patient representative name (please print)‡ | **Date***

If signed by patient representative, you must indicate below the authority to act on behalf of patient§:

☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other: _____

†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡NOT required if patient signs.
§Required if patient representative signs.

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit Pfizer.com/privacy.

Questions? Call 1-833-956-3376, Monday–Friday, 8:00 AM to 8:00 PM ET.

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (*REQUIRED)

I authorize (i.e., allow) the use and/or disclosure of my Protected Health Information, described below, which is protected under a federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). In general, Protected Health Information is information, including demographic information, which (1) relates to my past, present, or future physical or mental health or condition, the provision of health care to me, or the past, present, or future payment for the provision of health care to me, and (2) that identifies me or for which there is a reasonable basis to believe can be used to identify me. I understand that this authorization is voluntary.

1. **Person(s) or Class of Person(s) Authorized to Disclose Protected Health Information:** My health care providers, including my treating physicians and medical laboratories, that provide health care to me and conduct medical testing.
2. **Person(s) or Class of Person(s) Authorized to Receive Protected Health Information:** Pfizer Inc. ("Pfizer"), Pfizer Dermatology Patient Access™ (the "Program") and other authorized service providers of Pfizer.
3. **Description of Protected Health Information that may be Used and/or Disclosed:** My name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that I am seeking health care services, and data otherwise related to my health condition, diagnosis, and/or treatment.
4. **Purpose(s) for the Use and/or Disclosure of Protected Health Information:** To determine whether conditions for eligibility under the Program have been met; and to provide me with various support to help me access a Pfizer medicine, which may include the following:

   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 copay support or free drug programs
   - 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
   - Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services
5. **No Conditioning.** I understand that my treatment, enrollment, eligibility and payment under my health plan are not conditioned upon me signing this form and agreeing to permit the disclosure of my Protected Health Information to Pfizer and its authorized service providers.
6. **Right to Revoke.** I may revoke (i.e., take back) this authorization at any time, except to the extent that my health care providers have taken any action in reliance on my authorization. I understand that if I revoke this authorization, it will not have any effect on any uses or disclosures of my Protected Health Information that occurred prior to receiving my revocation. To revoke, I understand that I must notify Pfizer Dermatology Patient Access by emailing patientprivacy@sonexushealth.com or by calling 1-833-956-DERM (1-833-956-3376) 8 AM–8 PM M–F ET.
7. **Expiration of Authorization.** This authorization will remain in full force and effect for two years from the date of this authorization, unless I revoke it prior to this time.
8. **Potential for Re-disclosure.** Persons or entities that receive my Protected Health Information under this authorization may not be required by privacy laws (such as HIPAA) to protect the information and they may share it with others without my permission, if permitted by laws that are applicable to them.
9. **Copy of Authorization.** I understand that I am entitled to receive a signed copy of this authorization.

I have read this authorization and/or had its contents read to me. I authorize the use and disclosure of my Protected Health Information as described in 1–9 above.

SIGN X _____ _____ _____

Patient Signature* (Patient or patient representative must be 18 years or older)† | Patient or patient representative name (please print)‡ | **Date***

If signed by patient representative, you must indicate below the authority to act on behalf of patient§:

☐Court Appointed ☐Parent/Guardian ☐Power of Attorney, including authority to make healthcare decisions ☐Other:_____

†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡NOT required if patient signs.
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CHECK IF APPLICABLE ☐ BENEFITS INVESTIGATION ONLY

☐ This prescription has also been sent to a Specialty Pharmacy Provider (SPP)

SPP Name _____ SPP Phone Number _____

Patient First Name* _____ **Last Name*** _____ **Date of Birth** (mm/dd/yyyy)* _____ **(*REQUIRED)**

FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page. Fax COMPLETED form with a cover sheet to 1-877-548-1734.

4. PRESCRIBER INFORMATION (*REQUIRED)

First Name* _____ **Last Name*** _____

NPI#* _____ **State License Number*** _____

Address* _____ **City*** _____ **State*** _____ **ZIP*** _____

Office Contact Name _____ **Office Phone Number*** _____ Ext. _____

Office Fax* _____ Email _____

5. DIAGNOSIS (*REQUIRED) – DO NOT ATTACH ANY CLINICAL OR OFFICE NOTES AS THIS MAY DELAY PROCESSING THE FORM

ICD-10 codes for CIBINQO:
- ☐ L20: Atopic Dermatitis
- ☐ L20.8: Other Atopic Dermatitis
- ☐ L20.9: Atopic Dermatitis, Unspecified

ICD-10 codes for LITFULO:
- ☐ L63: Alopecia Areata
- ☐ L63.0: Alopecia (Capitis) Totalis
- ☐ L63.1: Alopecia Universalis
- ☐ L63.2: Ophiasis
- ☐ L63.8: Other Alopecia Areata
- ☐ L63.9: Alopecia Areata, Unspecified
- ☐ Other _____

6. PRESCRIPTION INFORMATION – Directions for e-Prescribing are located in Section 7 (*Select one medication per enrollment form)

Interim Care Rx for CIBINQO and LITFULO: Only filled through Sonexus Health Pharmacy Services. By requesting this, you certify that you understand the terms and conditions on page 5.

Prescription for CIBINQO® (abrocitinib) tablets (up to 30 days, 30 tablets)		**Interim Care Rx for CIBINQO (11 Refills):** (up to 30 days, 30 tablets)	**Voucher Rx for CIBINQO:** (One-time 30-day supply)
☐ 50 mg PO once daily	Refills _____	☐ 50 mg PO once daily	☐ 50 mg PO once daily
☐ 100 mg PO once daily	Refills _____	☐ 100 mg PO once daily	☐ 100 mg PO once daily
☐ 200 mg PO once daily	Refills _____	☐ 200 mg PO once daily	☐ 200 mg PO once daily

Prescription for LITFULO® (ritlecitinib) capsules (up to 28 days, 28 capsules)		**Interim Care Rx for LITFULO (11 Refills):** (up to 28 days, 28 capsules)	**Voucher Rx for LITFULO:** (One-time 28-day supply)
☐ 50 mg PO once daily	Refills _____	☐ 50 mg PO once daily	☐ 50 mg PO once daily

Drug Allergies ☐ No ☐ Yes (If yes, please list medication[s] and associated reaction[s]): _____

Concomitant Medications: _____

7. Healthcare Provider CERTIFICATION Prescriber Signature — NO STAMPS (*REQUIRED)

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.

I also give my permission to receive calls related to Program services from Pfizer, Pfizer Dermatology Patient Access™, and parties acting on their behalf.

SIGN X _____ _____

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

_____

Print Name of Healthcare Provider

***e-Prescribe ID (NCPDP: 5910206; NPI: 1447680210).** If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying that you have received patient consent for Sonexus Health Pharmacy Services and Pfizer Dermatology Patient Access™ to contact your patient and provide them services. Sonexus Health Pharmacy Services is categorized as a retail pharmacy in EMR/EHR systems and is located at 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067.

If you are a prescriber based in New York state, please use a New York state prescription form.

CIBINQO® (abrocitinib) and LITFULO® (ritlecitinib) Interim Care Rx Program: TERMS AND CONDITIONS

Interim Care 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 CIBINQO® (abrocitinib) or LITFULO® (ritlecitinib). 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 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 or Michigan. For residents of Minnesota or Rhode Island, available for up to six months. Available up to a 30-day supply. Refills are subject to limitations. Interim Care 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 can only be dispensed by the exclusive pharmacy and only after a benefits investigation has been completed and a delay occurs in the Prior Authorization process, or an appeal is required. 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. Patients whose insurance plans have established a product exclusion for either CIBINQO or LITFULO are not eligible to participate and/or continue participation in the Interim Care Program. Continued eligibility for the program requires, 1. submission of first appeal within 60 days of enrollment (or within the required payer timeline, if sooner) in the Interim Care Program and submission of the second appeal, if allowed by the payer, within 60 days of the date of the first appeal denial (or within the required payer timeline, if sooner), 2. satisfying all payer appeal requirements and 3. patients schedule their initial prescription dispense within 60 days of enrollment. If at any time during the patient's Interim Care Program enrollment there is a payer coverage change relating to the applicable product, Pfizer may conduct a new benefits investigation, and, if allowed by the payer, submission of a new Prior Authorization request and an appeal, if denied, must be submitted within 60 days (or within the required payer timeline, if sooner) of either, 1. the date of completion of the benefits investigation, provided by the Pfizer Dermatology Patient Access Program to the patient's authorized healthcare provider, or 2. the date a new submission is allowed by the payer, for continued eligibility in the program, whichever is later. If there is no payer coverage change, at 12 months of Interim Care Program enrollment, an updated prescription and benefits investigation is required to confirm continued eligibility. All payer appeal timelines must be met for continued assistance. For eligible patients participating in the program that are not residents of Minnesota or Rhode Island, assistance may be available for up to two years in total, which is the lifetime maximum per patient. The Interim Care Program is applicable to all CIBINQO® (abrocitinib) or LITFULO® (ritlecitinib) formulations. Additional eligibility criteria may apply. Contact Pfizer Dermatology Patient Access™ at 1-833-956-DERM (1-833-956-3376) for details.

VOUCHER TERMS AND CONDITIONS FOR THE PATIENT

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 CIBINQO or 28-day supply of LITFULO. Only new patients may use this voucher and each patient is limited to one voucher. By redeeming this voucher, you certify that you are not currently using CIBINQO or LITFULO. This voucher may not be transferred, sold, purchased, traded, or counterfeited. 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).** This voucher is not valid where prohibited by law. This voucher cannot be combined with any other external savings, free trial, or similar offer for the specified prescription. This voucher should not be combined with samples for the specified prescription. **This free trial voucher is not health insurance. This free trial voucher may not be used 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 CIBINQO or LITFULO. Pfizer reserves the right to rescind, revoke, or amend this offer without notice. This voucher expires 12/31/2027.

PFIZER DERMATOLOGY patient access™

PLEASE PROVIDE THIS PAGE TO THE PATIENT DURING THEIR VISIT

Your doctor has sent your prescription(s) to Pfizer Dermatology Patient Access™ to help you with your access to CIBINQO® (abrocitinib) or LITFULO® (ritlecitinib).

Please call 1-833-956-DERM (1-833-956-3376) today
to discuss how Pfizer Dermatology Patient Access™ may be able to help

SCAN and save the Pfizer Dermatology Patient Access™ contact information to your phone.

Pfizer is not accessing data on the user's phone.

Pfizer Dermatology Patient Access™ will work with you to determine if you have coverage for CIBINQO or LITFULO through your insurance.

What to expect:

A Patient Support Representative from Pfizer Dermatology Patient Access™ will call you when your prescription is received. The number will be displayed as 1-833-956-3376 on your caller ID.

Topics discussed during the call may include:

- Requests for missing information
- Insurance coverage information
- Pharmacy preference

Once coverage through your insurance plan has been determined and approved, your medication will be either delivered to you by a specialty pharmacy or transferred to a pharmacy of your choice.

Please see full Prescribing Information, including **BOXED WARNING**, and Medication Guide for CIBINQO®, and full Prescribing Information, including **BOXED WARNING**, and Medication Guide for LITFULO®.