PFIZER DERMATOLOGY
patient access™

Navigating the Prescription and Patient Enrollment Form

For assistance or additional information, call Pfizer Dermatology Patient Access™ at **1-844-496-8707**, Monday - Friday, 8:00 AM to 8:00 PM ET, or visit **PDPAresources.com.**

Pfizer

IMPORTANT

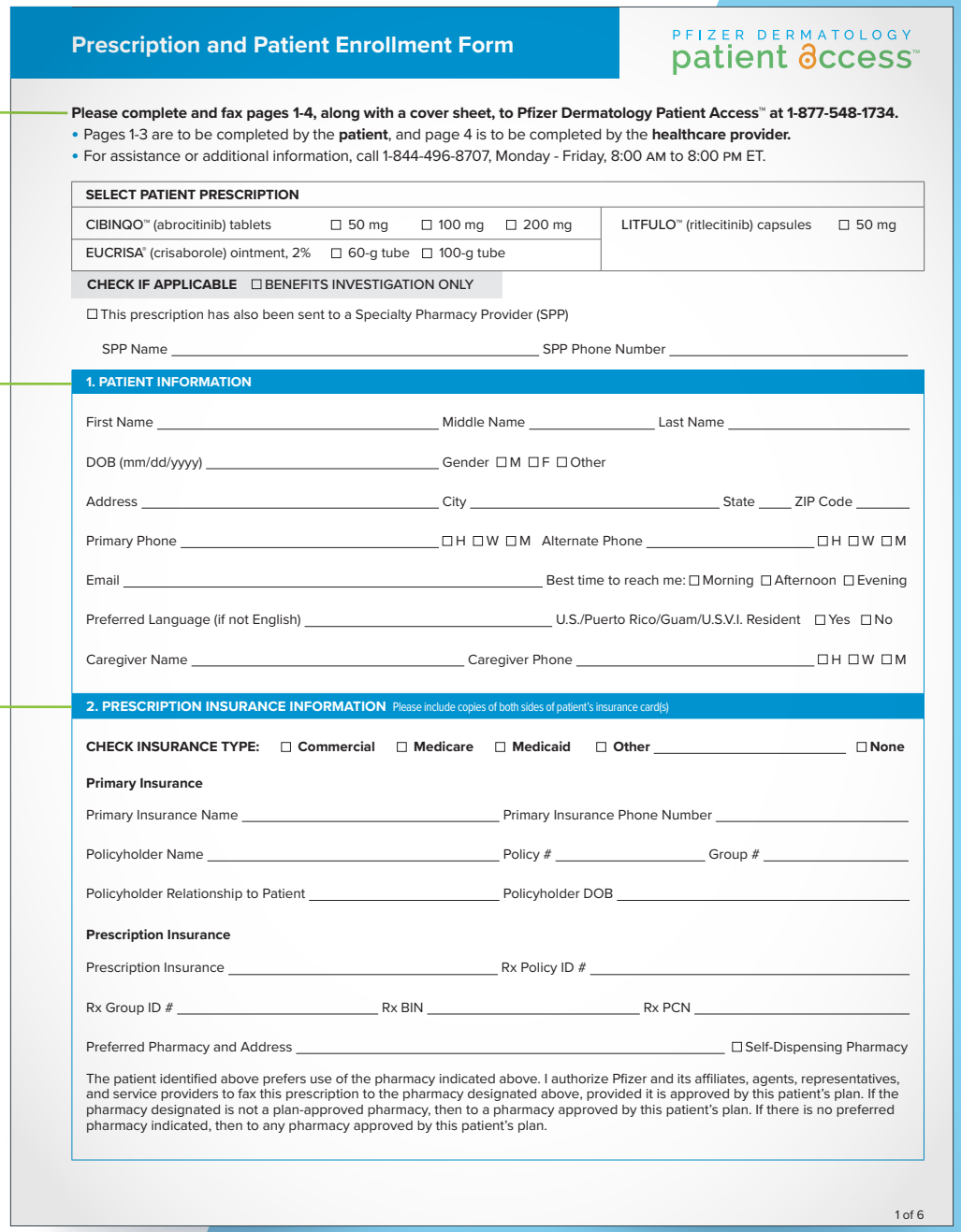
To request copay assistance only, please visit PDPACopayCard.com. Patients do not need to complete this form.

1. PATIENT INFORMATION

- Provide Patient Information, including Date of Birth
- Ensure the patient provides their Preferred Language, if other than English, and Caregiver Information

2. PRESCRIPTION INSURANCE INFORMATION

- Check the appropriate box for the patient's insurance type, or check None is the patient has no insurance
- Fill in all insurance information for the patient. When faxing the enrollment form, including a copy of the front and back of the patient's insurance card(s) to facilitate benefits investigation and processing



Prescription and Patient Enrollment Form

PFIZER DERMATOLOGY patient access™

Please complete and fax pages 1-4, along with a cover sheet, to Pfizer Dermatology Patient Access™ at 1-877-548-1734.

- Pages 1-3 are to be completed by the **patient**, and page 4 is to be completed by the **healthcare provider.**
- For assistance or additional information, call 1-844-496-8707, Monday - Friday, 8:00 AM to 8:00 PM ET.

SELECT PATIENT PRESCRIPTION

CIBINQO™ (abrocitinib) tablets ☐ 50 mg ☐ 100 mg ☐ 200 mg

EUCRISA® (crisaborole) ointment, 2% ☐ 60-g tube ☐ 100-g tube

LITFULO™ (ritlecitinib) capsules ☐ 50 mg

CHECK IF APPLICABLE ☐ BENEFITS INVESTIGATION ONLY

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

SPP Name _____ SPP Phone Number _____

1. PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____

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

Address _____ City _____ State ____ ZIP Code _____

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

Email _____ 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

2. PRESCRIPTION INSURANCE INFORMATION Please include copies of both sides of patient's insurance card(s)

CHECK INSURANCE TYPE: ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Other** _____ ☐ **None**

Primary Insurance

Primary Insurance Name _____ Primary Insurance Phone Number _____

Policyholder Name _____ Policy # _____ Group # _____

Policyholder Relationship to Patient _____ Policyholder DOB _____

Prescription Insurance

Prescription Insurance _____ Rx Policy ID # _____

Rx Group ID # _____ Rx BIN _____ Rx PCN _____

Preferred Pharmacy and Address _____ ☐ Self-Dispensing Pharmacy

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.

1 of 6

3A. PATIENT CONSENT TO RECEIVE COMMUNICATIONS

- The Patient or Patient Representative signature authorizes Pfizer to provide patient communication, services, and information relating to their prescribed Pfizer medication. Your patient may call Pfizer Dermatology Patient Access™ at any time to opt out of the communications described
- Checking the box and providing an email address gives permission for email communications
- Checking the box and providing a cell phone number gives permission for text communications*
- If signed by a Patient Representative, check one of the boxes to indicate the type of legal authority to act on behalf of the patient

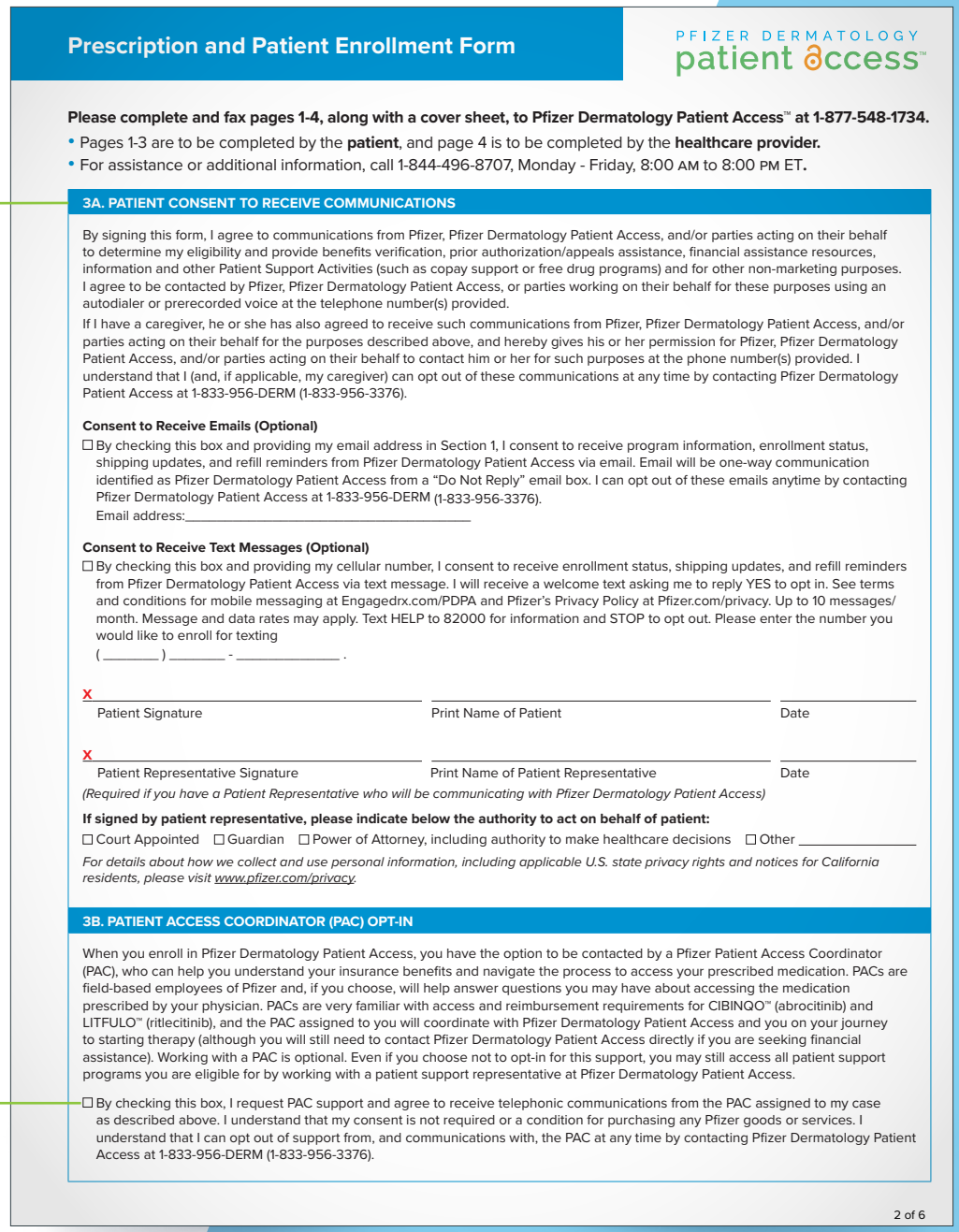
IMPORTANT

A signed and dated Patient Authorization to Share Health Information Form must be submitted in order for the patient to receive assistance. The Patient Authorization to Share Health Information Form is found on page 4.

3B. PATIENT ACCESS COORDINATOR (PAC) OPT-IN

Remind your patient to opt in to receive support throughout their medication access journey from a Patient Access Coordinator (PAC).

*Message and data rates may apply.



Prescription and Patient Enrollment Form

PFIZER DERMATOLOGY patient access™

Please complete and fax pages 1-4, along with a cover sheet, to Pfizer Dermatology Patient Access™ at 1-877-548-1734.

- Pages 1-3 are to be completed by the **patient**, and page 4 is to be completed by the **healthcare provider.**
- For assistance or additional information, call 1-844-496-8707, Monday - Friday, 8:00 AM to 8:00 PM ET**.**

3A. PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing this form, I agree to communications from Pfizer, Pfizer Dermatology Patient Access, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, information and other Patient Support Activities (such as copay support or free drug programs) and for other non-marketing purposes. I agree to be contacted by Pfizer, Pfizer Dermatology Patient Access, 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, Pfizer Dermatology Patient Access, and/or parties acting on their behalf for the purposes described above, and hereby gives his or her permission for Pfizer, Pfizer Dermatology Patient Access, and/or parties acting on their behalf to contact him or her for such purposes at the phone number(s) provided. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376).

Consent to Receive Emails (Optional)

☐ By checking this box and providing my email address in Section 1, I consent to receive program information, enrollment status, shipping updates, and refill reminders from Pfizer Dermatology Patient Access via email. Email will be one-way communication identified as Pfizer Dermatology Patient Access from a "Do Not Reply" email box. I can opt out of these emails anytime by contacting Pfizer Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376).
Email address:_____

Consent to Receive Text Messages (Optional)

☐ By checking this box and providing my cellular number, I consent to receive enrollment status, shipping updates, and refill reminders from Pfizer Dermatology Patient Access via text message. I will receive a welcome text asking me to reply YES to opt in. See terms and conditions for mobile messaging at Engagedrx.com/PDPA and Pfizer's Privacy Policy at Pfizer.com/privacy. Up to 10 messages/month. Message and data rates may apply. Text HELP to 82000 for information and STOP to opt out. Please enter the number you would like to enroll for texting
(_____) _____ - _____ .

X_____ _____ _____
Patient Signature | Print Name of Patient | Date

X_____ _____ _____
Patient Representative Signature | Print Name of Patient Representative | Date

(Required if you have a Patient Representative who will be communicating with Pfizer Dermatology Patient Access)

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

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

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.

3B. PATIENT ACCESS COORDINATOR (PAC) OPT-IN

When you enroll in Pfizer Dermatology Patient Access, you have the option to be contacted by a Pfizer Patient Access Coordinator (PAC), who can help you understand your insurance benefits and navigate the process to access your prescribed medication. PACs are field-based employees of Pfizer and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. PACs are very familiar with access and reimbursement requirements for CIBINQO™ (abrocitinib) and LITFULO™ (ritlecitinib), and the PAC assigned to you will coordinate with Pfizer Dermatology Patient Access and you on your journey to starting therapy (although you will still need to contact Pfizer Dermatology Patient Access directly if you are seeking financial assistance). Working with a PAC is optional. Even if you choose not to opt-in for this support, you may still access all patient support programs you are eligible for by working with a patient support representative at Pfizer Dermatology Patient Access.

☐ By checking this box, I request PAC support and agree to receive telephonic communications from the PAC assigned to my case as described above. I understand that my consent is not required or a condition for purchasing any Pfizer goods or services. I understand that I can opt out of support from, and communications with, the PAC at any time by contacting Pfizer Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376).

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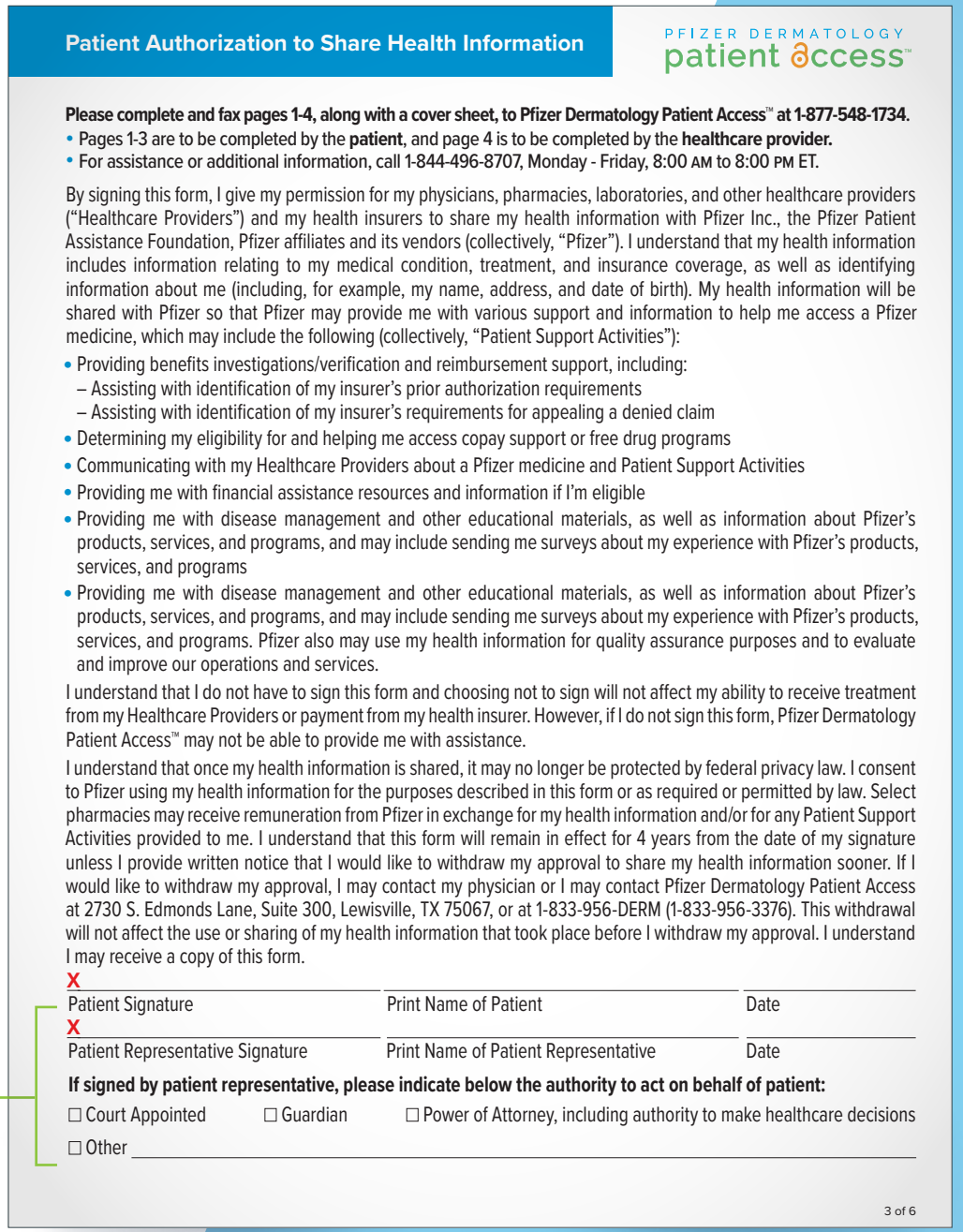
PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION FORM

Please ensure your patient understands that signing this form allows Pfizer Dermatology Patient Access™ to provide ongoing support for their prescribed Pfizer Dermatology medications.

- If signed by a Patient Representative, check one of the boxes to indicate the type of legal authority to act on behalf of the patient

IMPORTANT

The form must be signed, dated, and returned to Pfizer Dermatology Patient Access™.



Patient Authorization to Share Health Information

PFIZER DERMATOLOGY patient access™

Please complete and fax pages 1-4, along with a cover sheet, to Pfizer Dermatology Patient Access™ at 1-877-548-1734.

- Pages 1-3 are to be completed by the **patient**, and page 4 is to be completed by the **healthcare provider.**
- For assistance or additional information, call 1-844-496-8707, Monday - Friday, 8:00 AM to 8:00 PM ET.

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 (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 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
- 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's products, services, and programs
- 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's 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, Pfizer Dermatology Patient Access™ 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. I consent to Pfizer using my health information 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 Pfizer Dermatology Patient Access at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, or at 1-833-956-DERM (1-833-956-3376). 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.

X _____ _____ _____

Patient Signature | Print Name of Patient | Date

X _____ _____ _____

Patient Representative Signature | Print Name of Patient Representative | Date

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

☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions

☐ Other _____

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Fax the completed form (pages 1 – 4) to Pfizer Dermatology Patient Access at **1-877-548-1734**

IMPORTANT

Patient full name and DOB are required

4. HEALTHCARE PROVIDER INFORMATION

All fields are required. The Office Contact and Phone Number facilitate communication with Pfizer Dermatology Patient Access™ and the designated pharmacy.

5. CLINICAL INFORMATION

Enter the appropriate ICD-10 code.

IMPORTANT

DO NOT attach any clinical or office notes as this may delay form processing.

6. PRESCRIPTION

Check only one box in Section 6, and fill in the Quantity and number of Refills.

IMPORTANT

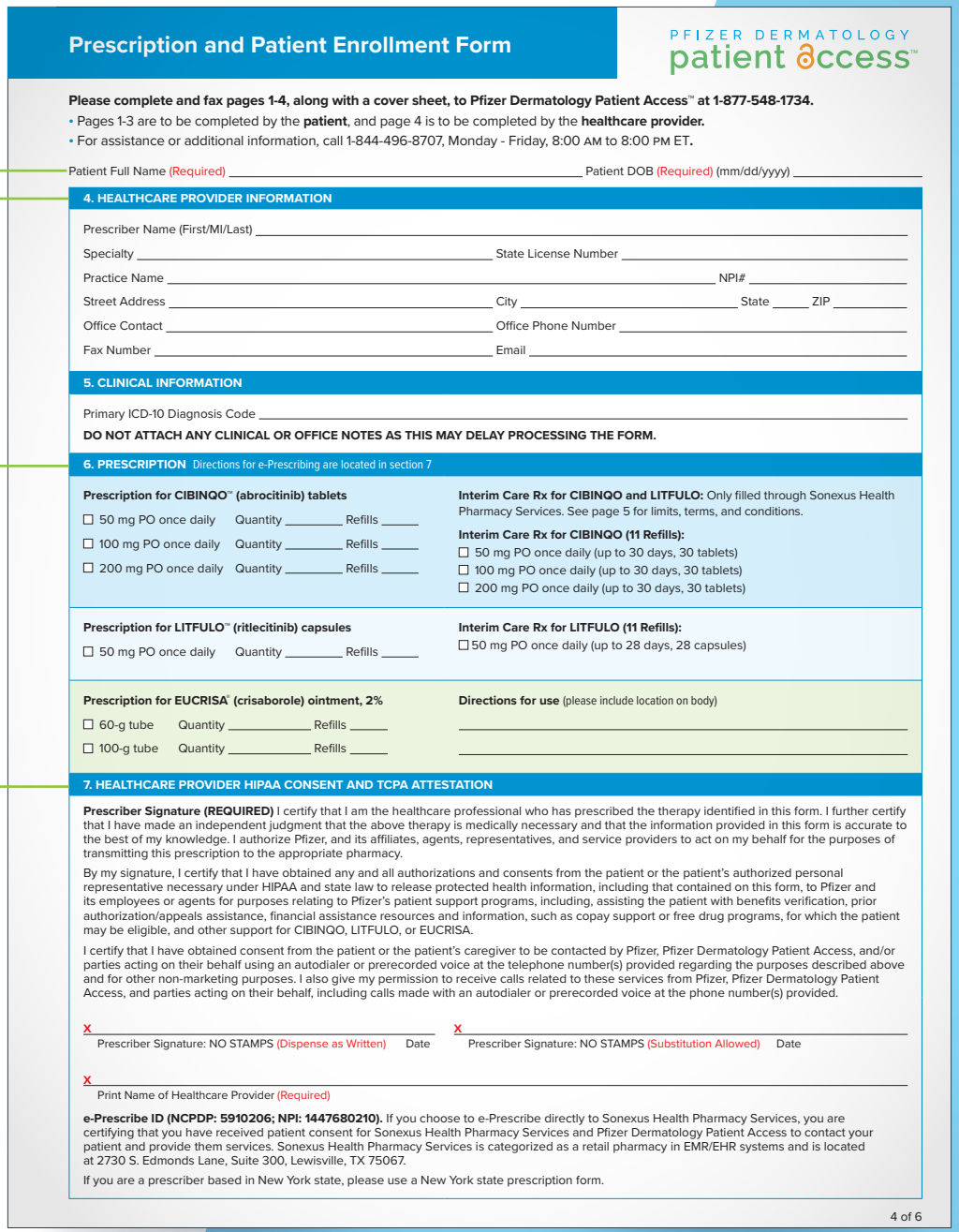
Each product requires its own separate prescription.

7. HEALTHCARE PROVIDER CERTIFICATION

Sign in one place: on the left to Dispense as Written, **or** on the right if Substitution is Allowed.

IMPORTANT

Actual Prescriber Signature is required to process the prescription. Please **DO NOT** use the Prescriber Signature stamp.



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

4. HEALTHCARE PROVIDER INFORMATION

Prescriber Name (First/MI/Last) _____

Specialty _____ State License Number _____

Practice Name _____ NPI# _____

Street Address _____ City _____ State ____ ZIP _____

Office Contact _____ Office Phone Number _____

Fax Number _____ Email _____

5. CLINICAL INFORMATION

Primary ICD-10 Diagnosis Code _____

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

6. PRESCRIPTION Directions for e-Prescribing are located in section 7

Prescription for CIBINQO™ (abrocitinib) tablets

☐ 50 mg PO once daily Quantity _____ Refills ____

☐ 100 mg PO once daily Quantity _____ Refills ____

☐ 200 mg PO once daily Quantity _____ Refills ____

Interim Care Rx for CIBINQO and LITFULO: Only filled through Sonexus Health Pharmacy Services. See page 5 for limits, terms, and conditions.

Interim Care Rx for CIBINQO (11 Refills):

☐ 50 mg PO once daily (up to 30 days, 30 tablets)

☐ 100 mg PO once daily (up to 30 days, 30 tablets)

☐ 200 mg PO once daily (up to 30 days, 30 tablets)

Prescription for LITFULO™ (ritlecitinib) capsules

☐ 50 mg PO once daily Quantity _____ Refills ____

Interim Care Rx for LITFULO (11 Refills):

☐ 50 mg PO once daily (up to 28 days, 28 capsules)

Prescription for EUCRISA® (crisaborole) ointment, 2%

☐ 60-g tube Quantity _____ Refills ____

☐ 100-g tube Quantity _____ Refills ____

Directions for use (please include location on body)

_____

_____

7. HEALTHCARE PROVIDER HIPAA CONSENT AND TCPA ATTESTATION

Prescriber Signature (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.

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 copay support or free drug programs, for which the patient may be eligible, and other support for CIBINQO, LITFULO, or EUCRISA.

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

X _____ X _____

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

X _____

Print Name of Healthcare Provider (Required)

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.

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PATIENT INSTRUCTIONS

After completing the enrollment form, share this page with your patients so they have important Pfizer Dermatology Patient Access™ contact information readily available.

IMPORTANT – QR CODE

Patients will be able to recognize calls from Pfizer Dermatology Patient Access™ once they scan this QR code to save our contact information to their phones.

- Patients answering calls from the Support Representative enables timely communication and helps prevent delays due to missing information

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Patient Instructions

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), LITFULO™ (ritlecitinib), or EUCRISA® (crisaborole).

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, LITFULO, or EUCRISA 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™.

Pfizer

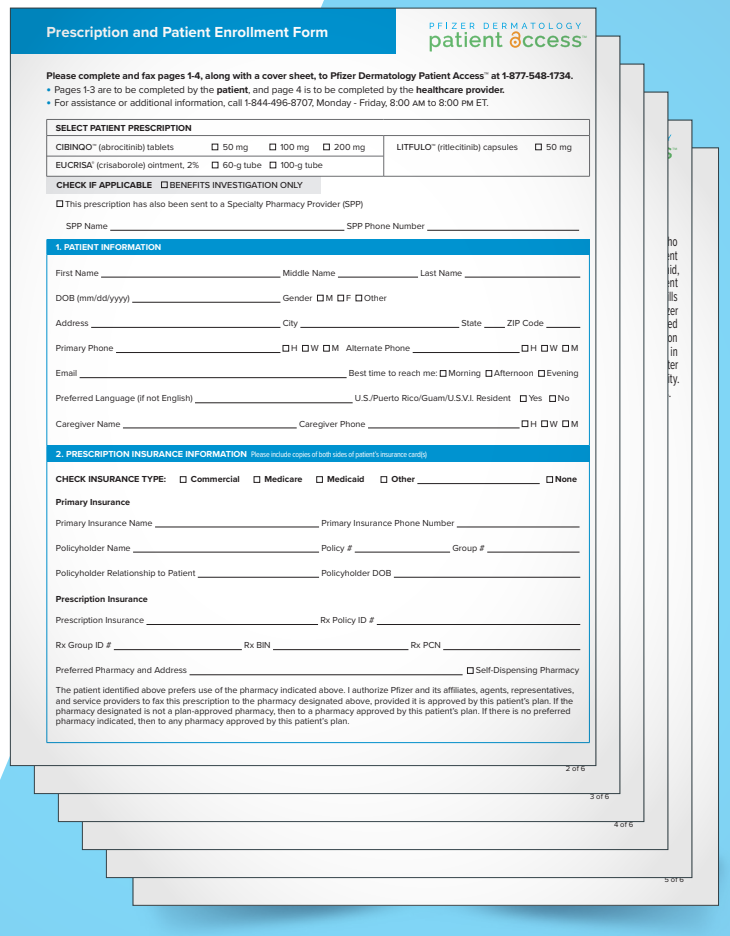
3 Ways to Enroll Your Patient

e-Prescribe: Send prescription directly to Sonexus Health Pharmacy Services* **(NCPDP: 5910206; NPI: 1447680210)**

HCP Portal: Log in or register at **PfizerDermatologyHCPPortal.com**

Fax a completed and signed Prescription and Patient Enrollment Form to **1-877-548-1734**

- Remember to have the patient sign the required consents



DON'T FORGET

Following these important steps when completing the Prescription and Patient Enrollment Form can reduce the potential for delays in medication access:

- **DO NOT** attach any clinical or office notes as this may delay form processing
- Actual Prescriber Signature is required to process the prescription. Please **DO NOT** use the Prescriber Signature stamp
- A signed and dated Patient Authorization to Share Health Information Form (page 4) must be submitted in order for the patient to receive assistance
- Provide your patient with the **Patient Instructions** (page 6), which enables them to scan and save the Pfizer Dermatology Patient Access™ contact information
- Fax the completed, signed, and dated enrollment form (including patient authorization) to Pfizer Dermatology Patient Access™ at **1-877-548-1734**

For assistance or additional information, call Pfizer Dermatology Patient Access™ at **1-844-496-8707**, Monday - Friday, 8:00 AM to 8:00 PM ET, or visit **PDPAresources.com.**

* 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.

Pfizer