PFIZER PATIENT ASSISTANCE PROGRAM*

PFIZER DERMATOLOGY patient access™

TELEPHONE: 1-844-496-8707 **FAX:** 1-877-548-1734 **ADDRESS:** 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

PATIENT APPLICATION

Please complete the form where applicable and return via mail or fax. All pages must be returned to Pfizer Dermatology Patient Access™.

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

PATIENT INFORMATION	Name:		Date of Birth (DOB):
	Address:		
	City:	State:	ZIP:
	Telephone (Day):	Telephone (Evening):	
	E-mail:		
INSURANCE INFORMATION (If re-enrolling provide your insurance information if it has changed since your last enrollment) NOTE: Patients with commercial insurance are not eligible for the Pfizer Patient Assistance Program even if the medication is not covered by their commercial insurance plan.	☐ **I confirm that I do not have prescription drug coverage**		
	Check insurance type: ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Other** _____ ☐ **None**		
	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 #:	
	Policy Holder First Name:	Policy Holder Last Name:	
	Policy Holder DOB:	Policy Holder Relationship to Patient:	
	Medicare Part D Insurance Mailing Address:		
	City:	State:	ZIP:
PATIENT FINANCIAL INFORMATION	**Total Number of People Within Household (including applicant):** _____ **Total Annual Income for Entire Household: $** _____ (Annual household income may include current salary, Social Security, unemployment insurance benefits, workers compensation, and income from other sources.) **If you do not want your income to be verified electronically, please submit the required documentation outlined below.** **Attached is:** ☐ **Most recent federal tax return (1040 form)** ☐ **W-2 form** ☐ **Other** We must receive proof of income to determine eligibility for assistance. 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 from the date of the signature on this form through the enrollment period (unless a shorter timeframe 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 (Patient or Patient Representative must be 18 or older) **Patient Representative Name (Please Print)** **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 _____

The information you provide will be used by Pfizer Inc. ("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. If I am a commercially insured patient applying after January 1, 2024, I cannot receive assistance through the Pfizer Patient Assistance Program even if my prescription is not covered by the commercial insurance plan. Any employer funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that I am a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan.

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 Authorization to Share Health Information form on record with my Prescriber so that my Prescriber may share health information about me with the Pfizer Patient Assistance Program, Pfizer, 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 (Patient or Patient Representative must be 18 or older) **Patient Representative Name (Please Print)** **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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PFIZER DERMATOLOGY patient access™

Patient Authorization to Share Health Information – This must be signed and returned to Pfizer Dermatology Patient Access to receive assistance.

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.

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 my 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, 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. However, I consent to Pfizer using 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 state law requires a shorter period or unless I provide written notice that I would like to withdraw my approval to share my health information sooner. I may withdraw my consent at any time. If I would like to withdraw my approval, I may contact my physician, or I may contact Pfizer Dermatology Patient Access at 1-833-956-3376 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.

X _____ _____ _____

Patient Signature (Patient or Patient Representative must be 18 or older) | **Patient Representative Name (Please Print)** | **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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HCP TO COMPLETE **Please complete the form where applicable and return via mail or fax. All pages must be returned to Pfizer Dermatology Patient Access™.**

IMPORTANT NOTE: Commercially Insured patients are not eligible for assistance even if the medication is not covered by the commercial insurance plan. Patients must have an FDA-approved diagnosis to be considered for the Pfizer Patient Assistance Program.

☐ **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:	
	Contact E-mail Address:		Fax:	

PRESCRIBER CERTIFICATION

The information you provide will be used by Pfizer Inc. ("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.

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, and I have prescribed the product for an FDA-approved indication. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I understand that commercially insured patients are not eligible for the Pfizer Patient Assistance Program , even if my prescription is not covered by the commercial insurance plan. Any employer funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that I am a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan. If the patient has Medicare Part D, Pfizer will notify the Medicare Part D Plan of their participation in the Pfizer Patient Assistance Program. 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 Patient Authorization to Share Information Form so that I may share patient health information with the Pfizer Patient Assistance Program, Pfizer Inc., and the Pfizer Patient Assistance Foundation™.

	Prescriber Signature X	Date:

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

CLINICAL AND PRESCRIPTION INFORMATION NOTE: Patient must have an on-label diagnosis to be considered for the Pfizer Patient Assistance Program	Patient First Name:	Patient Last Name:	
	Patient DOB:	Patient Phone:	
	Primary ICD-10:	Secondary ICD-10:	
	Rx: ☐ CIBINQO™ (abrocitinib) 50-mg tablets PO QD, 30-day supply ☐ CIBINQO™ (abrocitinib) 100-mg tablets PO QD, 30-day supply ☐ CIBINQO™ (abrocitinib) 200-mg tablets PO QD, 30-day supply ☐ LITFULO™ (ritlecitinib) 50-mg capsules PO QD, 28-day supply	☐ EUCRISA® (crisaborole) 60-g tube, 30-day supply ☐ EUCRISA® (crisaborole) 100-g tube, 30-day supply **Directions for use** (please include location on body):	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. e-Prescriptions should be sent to Sonexus Health Pharmacy Services, 2730 S. Edmonds Lane, Suite 400, Lewisville, TX 75067 (NCPDP: 5910206; NPI: 1447680210). If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying you have received patient consent for Sonexus Health Pharmacy Services and Pfizer Dermatology Patient Access to contact your patient and provide them services.

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