Patient Assistance Program* Enrollment Form

QUESTIONS? Call 1-833-956-3376, M–F, 8 AM–8 PM ET

PFIZER DERMATOLOGY patient access™

FOR PATIENTS: COMPLETE THIS FORM ONLINE at PfizerDermatologyPatientPortal.com (paper version is not needed if the form is completed online)

For patients: UPLOAD online at PfizerDermatologyPatientPortal.com or **FAX** completed forms to **1-877-548-1734**

FOR PATIENTS – Complete the following sections; then, read, sign, and date (where applicable) the required authorization and consents on pages 1–4.

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

1 PATIENT INFORMATION (*REQUIRED)

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

Date of Birth (mm/dd/yyyy)* _____ Gender: ☐ Male ☐ Female ☐ Other

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

Cell Phone _____ ***(Required for participation in texting services**, see Consent to Receive Text Messages on page 3)*

Alternate Phone* _____ ☐ H ☐ W Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Patient Email _____ Preferred Language _____

Caregiver Name _____ Phone _____ Email _____

2 INSURANCE INFORMATION (*REQUIRED) ☐ Check here if you are reapplying and your insurance information has not changed

NOTE: Patients with commercial insurance are not eligible for the Pfizer Patient Assistance Program, even if the medication is not covered by the commercial insurance plan.

My provider or pharmacy has reviewed my insurer-required product costs with me and I certify that I am unable to afford this.* ☐ Yes ☐ No

If yes, and not provided by your healthcare provider in section 14, the four fields below are required and can be completed by the patient/caregiver, the healthcare provider, or both.

Insurer required copayment (after Prior Authorization, if required)* _____ **Out-of-pocket (OOP) maximum for prescriptions*** _____

Amount met towards OOP max* _____ **Date information obtained from insurance plan/pharmacy*** _____

Insurance Type* (Check all that apply): ☐ Commercial/Employer ☐ Medicare Part D ☐ Medicare Advantage† ☐ Medicare A/B only ☐ Medicaid ☐ VA Benefits ☐ Other Off _____ ☐ No insurance

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

Medicare Part D Insurance (Required for all Medicare Part D patients)

Address City State ZIP

3 CERTIFICATION FOR MEDICARE PART D/MEDICARE ADVANTAGE PATIENTS ONLY (*REQUIRED)

By signing below, I certify that I:

- **Have enrolled in the Medicare Prescription Payment Plan† and will provide proof of enrollment** (allows patients to pay their prescription drug costs in capped monthly payments instead of all at once),
- **Understand my prescription costs after my healthcare provider has obtained Prior Authorization** (if required by my insurer) and that, once I meet my out-of-pocket maximum, I will have to pay $0 for covered medicines for the remainder of the year,
- **Have NOT paid, nor am I already responsible for paying, my $2,000 total prescription costs for the year** which I am requesting assistance (my out-of-pocket maximum has not been met),
- And **cannot afford my prescription cost** for the Pfizer Product(s) prescribed.

SIGN X _____ _____ _____

Patient or patient representative signature* (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 _____

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†The Pfizer Patient Assistance Program requires prior enrollment in the voluntary Medicare Prescription Payment Plan for applicable products covered and reimbursed by Medicare Part D/Medicare Advantage Plans. Contact your prescription health insurance plan to learn more.

‡Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted above can sign on their behalf.

§NOT required if patient signs.

¶Required if patient representative signs.

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FOR PATIENTS

4 PATIENT FINANCIAL INFORMATION (*REQUIRED)

Total Number of People Within Household (including applicant)* _____ **Total Pre-tax Annual Household Income* $** _____

If you choose not to consent to Electronic Income Verification in section 5, you must submit income documentation for all contributing household members to support the financial information you've listed.

Attached is: ☐ Most recent federal tax return (1040/1040-SR form)—**Required unless tax return is not filed** ☐ W-2 form ☐ Other _____

Estimated Out-of-Pocket Medical Expenses for the Year Assistance is Being Requested _____

(This should include any insurance premiums, deductibles, copayments, prescription costs, and any expected medical bills for the PAP applicant only.)

5 PATIENT AUTHORIZATION FOR ELECTRONIC INCOME VERIFICATION (Optional, but may reduce application review time)

By signing and dating below, 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 Pfizer Dermatology Patient Access, 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.

SIGN X _____ _____ _____

Patient or patient representative signature* (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 _____

6 PFIZER PATIENT ASSISTANCE PROGRAM CERTIFICATION (*REQUIRED)

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 HIPAA Authorization for Use and Disclosure of Protected 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.

SIGN X _____ _____ _____

Patient or patient representative signature* (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 _____

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†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted above can sign on their behalf.

‡NOT required if patient signs.

§Required if patient representative signs.

FOR PATIENTS

7 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.

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 or patient representative signature* (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 _____

8 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.

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†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted above can sign on their behalf.

‡NOT required if patient signs.

§Required if patient representative signs.

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FOR PATIENTS

9 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:
   - 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.
7. **Expiration of Authorization.** This authorization will remain in full force and effect for two years from the date of this authorization.
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 or patient representative signature* **(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 above can sign on their behalf.
‡ NOT required if patient signs.
§ Required if patient representative signs.

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PFIZER DERMATOLOGY patient access™

For Healthcare Professionals: UPLOAD online at PfizerDermatologyHCPPortal.com or **FAX** completed forms to **1-877-548-1734**

PATIENT INFORMATION **First name*** _____ MI ____ **Last name*** _____ **Date of Birth** (mm/dd/yyyy)* _____

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

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

10 PRESCRIBER INFORMATION (*REQUIRED)

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

NPI #* _____ **State License #*** _____ **Practice Name** _____

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

Office Contact Name* _____ **Office Contact Phone*** _____ **Office Fax*** _____

Email _____ Preferred Communication Method: ☐ Phone ☐ Fax

11 DIAGNOSIS (*REQUIRED) – Do not attach any clinical or office notes as this may delay processing the form

ICD-10 codes for CIBINQO and EUCRISA:

- ☐ 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 _____

12 PRESCRIPTION INFORMATION

Prescription for CIBINQO® (abrocitinib) tablets (up to 30 days, 30 tablets)

- ☐ 50 mg PO once daily Refills _____
- ☐ 100 mg PO once daily Refills _____
- ☐ 200 mg PO once daily Refills _____

Prescription for LITFULO® (ritlecitinib) capsules (up to 28 days, 28 capsules)

- ☐ 50 mg PO once daily Refills _____

Prescription for EUCRISA® (crisaborole) ointment, 2%

- ☐ 60-g tube Quantity _____ Refills _____
- ☐ 100-g tube Quantity _____ Refills _____

Directions for use (please include location on body)

_____

_____

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

Concomitant Medications: _____

13 SHIPPING INFORMATION (*REQUIRED)

Ship to*: ☐ Patient ☐ Prescriber ☐ Other (please provide shipping address—NO PHARMACIES) _____

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

SIGN X _____ _____

Prescribing Healthcare Provider Signature* – NO STAMPS **Date***

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PATIENT INFORMATION **First name*** _____ MI ____ **Last name*** _____ **Date of Birth** (mm/dd/yyyy)* _____

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

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

IMPORTANT NOTE: Commercially Insured patients are not eligible for assistance. Patients must have an FDA-approved diagnosis to be considered for the Pfizer Patient Assistance Program.

14 PRIOR AUTHORIZATION AND INSURER REQUIRED COSTS (*REQUIRED)

Does the insurance plan require a Prior Authorization?*: ☐ Yes ☐ No

Prior Authorization Number†* _____ **Prior Authorization Dates†*** _____

The product costs were obtained from the insurance plan/pharmacy and my patient has certified that they are unable to afford this.*: ☐ Yes ☐ No
If yes, and not provided by the patient in section 2, the four fields below are required and can be completed by either the healthcare provider, the patient, or both.

Insurer required copayment (after Prior Authorization, if required)* _____ **Out-of-pocket (OOP) maximum for prescriptions*** _____

Amount met towards OOP max* _____ **Date information obtained from insurance plan/pharmacy*** _____

15 PRESCRIBER CERTIFICATION (*REQUIRED)

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 their 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 the patient is 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 HIPAA Authorization for Use and Disclosure of Protected Health Information form so that I may share patient health information with the Pfizer Patient Assistance Program, Pfizer, and the Pfizer Patient Assistance Foundation Inc.

SIGN X _____ _____
Prescribing Healthcare Provider Signature* **Date***

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†Required if a Prior Authorization is required by the insurance plan.

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