Pfizer Oncology together™

Patient Support Program & Patient Assistance Enrollment Form

When applicable, check the box(es) below to be directed to appropriate sections to enroll in the following services provided by Pfizer Oncology Together:

- ☐ Benefits Verification
- ☐ Co-Pay Savings Program for Injectables
- ☐ Pfizer Patient Assistance Program
- ☐ Care Champion Program

Overview

Pfizer Oncology Together is a personalized patient support program that offers resources for patients prescribed Pfizer Oncology medicines. We provide access and reimbursement support, as well as help identifying financial assistance options, so patients can get their prescribed Pfizer Oncology medicines.

Pfizer is committed to working at every level to make the full potential of biosimilar medicines a reality across the communities we serve. However, for RUXIENCE™ and ZIRABEV™, the Prescribing Information does not include all of the indications of the original manufacturer's product. Please see Section 19 to confirm and acknowledge program limitations.

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.

Pfizer Oncology Together Patient Services

By enrolling in Pfizer Oncology Together, patients will receive various support and information to help access Pfizer medicine, which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of the insurer's prior authorization requirements
  - Assisting with identification of the insurer's requirements for appealing a denied claim
- Communicating with Healthcare Providers (HCPs) about a Pfizer medicine and Patient Support Activities
- Sending a device and starter kit (where appropriate)
- Provision of financial assistance resources and information, if eligible
- Determining eligibility for and helping with access to co-pay support or free drug programs (including the Pfizer Patient Assistance Program*)
- One-on-one assistance to help address day-to-day needs (opt-in required)
- Provision of disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending surveys about the patient's experience with Pfizer products, services, and programs

Patients Eligible for the Pfizer Patient Assistance Program

To qualify for free medicine, the patient must meet certain financial requirements, as well as meet the criteria below:

- Have a valid prescription for the Pfizer medicine for which they are seeking assistance
- Be 18 years of age or older
- Reside in the U.S. or a U.S. territory
- Be treated by a healthcare provider licensed in the U.S. or a U.S. territory
- Meet one of the following:
  - Have no insurance coverage or not enough coverage to pay for your Pfizer medicine listed above
  - Have been denied coverage by your insurer for the Pfizer medicine listed above (after an unsuccessful appeal to your insurer)
- Meet certain income limits (income limit is 500% of the federal poverty level)

Before enrolling in the Pfizer Patient Assistance Program, patients should be sure to fully use all co-pay assistance options available to them.

Orals

- ☐ AROMASIN® (exemestane)
- ☐ BOSULIF® (bosutinib)
- ☐ BRAFTOVI® (encorafenib)
- ☐ DAURISMO™ (glasdegib sodium)
- ☐ EMCYT® (estramustine phosphate sodium)
- ☐ IBRANCE® (palbociclib)
- ☐ INLYTA® (axitinib)
- ☐ LORBRENA® (lorlatinib)
- ☐ MEKTOVI® (binimetinib)
- ☐ SUTENT® (sunitinib malate)
- ☐ TALZENNA® (talazoparib)
- ☐ VIZIMPRO® (dacomitinib)
- ☐ XALKORI® (crizotinib)

Injectables

- ☐ BESPONSA® (inotuzumab ozogamicin)
- ☐ CAMPTOSAR® (irinotecan hydrochloride)
- ☐ ELLENCE® (epirubicin hydrochloride)
- ☐ IDAMYCIN® (idarubicin hydrochloride)
- ☐ MYLOTARG™ (gemtuzumab ozogamicin)
- ☐ TORISEL® (temsirolimus)

Injectable – Biosimilars

- ☐ NIVESTYM® (filgrastim-aafi)
- ☐ NYVEPRIA™ (pegfilgrastim-apgf)
- ☐ RETACRIT® (epoetin alfa-epbx)
- ☐ RUXIENCE™ (rituximab-pvvr)
- ☐ TRAZIMERA™ (trastuzumab-qyyp)
- ☐ ZIRABEV™ (bevacizumab-bvzr)

Your Color Coding Guide

Color coding indicates which sections of the form should be filled out by the

Patient or the HCP

*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.

Pfizer Oncology together™

TO BE COMPLETED BY PATIENT

Be sure your HCP faxes the **completed** form to 1-877-736-6506 or mail to: Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366. For questions, please call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

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Enrollment Checklist for Patients

Pages 2 and 3 should be completed by the patient or their caregiver. When completing these pages, keep the following points in mind:

- ✔ Include copies of the front and back of your medical and pharmacy insurance cards
- ✔ Include proof of income, such as page 1 of your tax return, if you are seeking financial assistance through the Pfizer Patient Assistance Program (PAP)†
- ✔ Review **Section 5** and check the box if you would like to opt in to the Care Champion program
- ✔ Check the appropriate boxes in **Section 5** if you would like to sign up for text message alerts from the Pfizer Patient Assistance Program and/or from Pfizer Oncology Together Care Champion
- ✔ Read all Patient Authorizations, Attestations, and Disclosures, then sign in **Section 5** to provide your consent

1. Patient Information

*Required fields

Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*	Sex* ☐ Male ☐ Female
Street Address*		
City*	State*	ZIP Code*
Phone* ☐ Home ☐ Mobile ☐ Work	Email Address	
Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening	Preferred Language (if not English)	
Caregiver Name	Caregiver Phone ☐ Home ☐ Mobile ☐ Work	
Patient Authorizations: ☐ I give permission to Pfizer Oncology Together to contact and leave messages for me about patient services and enrollment status.	☐ I give permission to Pfizer Oncology Together to communicate directly with my caregiver on my behalf.	

2. Patient Insurance Information

Check insurance type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other _____ ☐ None (skip to Section 3)

Primary Insurance*		Insurer's Phone*
Policy/Medicare Beneficiary ID #*	GRP ID #*	
Policyholder same as patient? ☐ Yes ☐ No	Relationship to Patient	
Policyholder Name*		Policyholder DOB (mm/dd/yyyy)
Secondary Insurance*		Insurer's Phone*
Policy/Medicare Beneficiary ID #*	GRP ID #*	
Policyholder same as patient? ☐ Yes ☐ No	Relationship to Patient	
Policyholder Name*		Policyholder DOB (mm/dd/yyyy)
Is the Pfizer medication covered by either medical or prescription insurance? ☐ Yes ☐ No ☐ I don't know	If yes, what is the co-pay amount? $	☐ I don't know
Prescription Insurance Name*		Prescription Policy ID #*
Prescription Group ID #*	Prescription BIN #	Prescription PCN #*

Are you enrolled in a Medicare Part D Prescription Drug Plan? ☐ Yes ☐ No (If Yes, please complete the information below. If No, skip to Section 3)

Provide your Medicare ID Number (HICN) or Medicare Beneficiary Number (MBI)

Medicare Part D Plan Name

Medicare Part D Plan Address

Note: Include copies of the front and back of your medical and pharmacy insurance cards with your enrollment form.

3. Patient Financial Information

This information is required to search for alternate funding support and verify eligibility for the Pfizer Patient Assistance Program, as appropriate.
Do not provide financial information if you are only applying for the Pfizer Oncology Together Co-Pay Savings Program for Injectables.

Total Number of People Within Household (including applicant)	Total Annual Household Income $

Please submit documentation to support the financial information you've listed. Attached is:
☐ Most recent federal tax return (Page 1 of IRS 1040 form) ☐ W-2 form ☐ Other

4. Pfizer Oncology Together Co-Pay Savings Program for Injectables

Check the appropriate box below if you are requesting enrollment in the Pfizer Oncology Together Co-Pay Savings Program for Injectables for the following product: NIVESTYM®, NYVEPRIA™, RUXIENCE™, TRAZIMERA™, and ZIRABEV™.

☐ Yes ☐ No I authorize the Pfizer Oncology Together Co-Pay Savings Program for Injectables ("Program") to provide payment directly to my healthcare provider, and not to me, for my out-of-pocket drug costs for my Pfizer Oncology medicine. I authorize my healthcare provider to contact the Program on my behalf to initiate payment for services after they have been rendered. I understand that I will be responsible for any out-of-pocket expenses for my Pfizer Oncology medicine if (1) my healthcare provider does not request payment within 120 days of the issue date on my Explanation of Benefits (EOB), or (2) if I am deemed ineligible for reimbursement from the Program.

☐ Yes ☐ No I attest that I am not enrolled in a state or federally funded insurance program, including but not limited to, Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud"). I attest that I am not over 65 years of age and retired. I attest that I do not receive Social Security Disability (SSDI) or any other Social Security Administration (SSA) benefit. I attest that I do not have End Stage Renal Disease (ESRD). I further attest that I am not active duty military nor are any of my immediate family members.

Terms and Conditions apply. For full Terms and Conditions for injectable products, please see PfizerOncologyTogether.com/injectables-terms and select the product that you are interested in.

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TO BE COMPLETED BY PATIENT

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5. Patient Authorizations, Attestations, and Disclosures

*Required fields

Personalized Patient Support Opt-in (Optional)

Personalized patient support is offered through Pfizer Oncology Together via Care Champion. You can speak with Care Champion for resources that may help with your daily life. Your Care Champion may provide information about your condition, Pfizer Oncology medicine, or topics such as nutrition, as well as a co-pay card offer for eligible patients. Care Champion can also connect you to independent organizations that provide services such as transportation and lodging for your treatment-related appointments. These offerings may vary based on your prescribed medicine. To opt in to this program, please check the box below.

☐ By checking this box, I request Care Champion support and agree to communications from Pfizer Oncology Together, Pfizer, and/or parties acting on their behalf. These communications may include calls to my phone number made with an autodialer about resources and other support such as those described above. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services. I understand that I can opt-out of these communications at any time by contacting Pfizer Oncology Together at 1-877-744-5675.

You can receive communications from the Care Champion program via text message.

☐ By checking this box, I consent to receive autodialed marketing and other texts from Pfizer and its service providers regarding the Pfizer Oncology Together Care Champion program at my mobile phone number, (_____)_____-_____. I understand that providing consent is not required or a condition of purchasing any products or services. Message and data rates may apply. Approximately 8 messages per month. Complete terms can be found at http://3csms.mobi/pfizer2/ and Pfizer's privacy policy at Pfizer.com/privacy. Reply STOP to opt-out.

Pfizer Patient Assistance Program† Certification, Attestation, and Privacy Disclosures

By signing the form, 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 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 out-of-pocket expenses for prescription drugs. I will not 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 Form on record with my HCP so that my HCP may share health information about me with Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation, Inc.

The information you provide will be used by Pfizer, Pfizer Oncology Together, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve Pfizer's assistance programs, to communicate with you about your experience with Pfizer's assistance programs, to help you understand your insurance coverage and help you access certain Pfizer medicines through your insurance, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

I understand that: completing this enrollment form does not guarantee that I will qualify for Pfizer's assistance programs. Pfizer may contact my insurer, to help me understand my insurance coverage for certain products and may provide me support to obtain coverage through my insurer, including prior authorization and appeals support (if necessary and available). Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by Pfizer's assistance programs shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel Pfizer's assistance programs, 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.

☐ Text me about my refills! By checking this box, I consent to receive refill reminders and shipping texts if I am accepted into the Pfizer Patient Assistance Program. I will receive a welcome text asking me to reply CONFIRM to opt in. Messages and data rates may apply. Number of messages varies based on program use, but is up to 5 texts per month. Reply STOP to cancel. Privacy policy and full Terms available here: www.pfizer.com/privacy. Please enter the number you would like to enroll for texting (_____)_____-_____.

Patient Consent to Receive Communications

By signing this form, I agree to receive communications from Pfizer, Pfizer Oncology Together, 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, Pfizer Oncology Together, 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 Oncology Together, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Oncology Together, 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 Pfizer Oncology Together at 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

Patient Signature* (Patient or personal representative of patient)	If personal representative, indicate relationship.	**Date***

Patient Email Address (Provide if signing electronically):

Patient Authorization for Electronic Income Verification (Optional – Only if applying for the Pfizer Patient Assistance Program†)

I, the applicant name below, understand that I am providing "written instructions" to Pfizer, Pfizer Oncology Together, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf under the Fair Credit Reporting Act authorizing the Pfizer Oncology Together to obtain information from my credit profile or other information from Experian™ Income View℠. I authorize Pfizer 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 for two (2) years from the date of the signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366, 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.

Patient Signature* (Patient or personal representative of patient)	If personal representative, indicate relationship.	**Date***

Patient Email Address (Provide if signing electronically):

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Pfizer Oncology together™

TO BE COMPLETED BY HCP

HCPs fax the **completed** form to 1-877-736-6506 or mail to: Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366. For questions, please call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

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Enrollment Checklist for HCP

Fill out every section of this page for all patient enrollment requests. Read the **Privacy and Consent** statements in Sections 9 and 10 and sign below. On the following pages:

- **Diagnosis:** Specify diagnosis in Section 12 for Oral and/or Injectable medications, and in Section 19 for Injectable Biosimilar Medications. For RUXIENCE™ or ZIRABEV™: Check the box and sign to acknowledge program limitations.
- **Directions/Dosing Instructions:** Complete Section 13 for Orals and/or Section 17 for Injectables
- **Sign the Prescription:** Sign Section 14 for Orals
- **Pfizer Patient Assistance Program:** For patients requesting enrollment for Orals and/or Injectables, Section 8 is required. For patients requesting enrollment for Injectable Biosimilars, Sections 8, 22, and 23 are required

Please Note: When e-prescribing, if you cannot find AmeriPharm (NPI number–1073692745; NCPDP number–4351968), you can also search for MedVantx under retail pharmacies (NPI number–1235371535; NCPDP number– 4354180). The prescription will be sent to the same place.

6. Patient Information

*Required fields

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*
Is your patient's Pfizer medication covered by either medical or prescription insurance? ☐ Yes ☐ No ☐ I don't know	If yes, what is their co-pay amount? $ ☐ I don't know

7. HCP/Site of Care Information

HCP Name (First/MI/Last)*			Professional Designation
Practice/Institution Name*	Address*		
City*		State*	ZIP Code*
NPI*	Group Tax ID*	State License*	DEA
Fax*	Email		

Site of Care Location*: ☐ Provider's office ☐ Hospital outpatient ☐ Hospital inpatient ☐ Other ☐ N/A

Contact Name*	Contact Phone*

8. Shipping Information for Pfizer Patient Assistance Program (PAP) Patients

(Required if requesting assistance through Pfizer Patient Assistance Program.†)

Patient Name*

Ship To*: ☐ HCP/Site of Care Address (Section 7) ☐ Patient Address (Section 1) ☐ Administering Provider Address (Section 20) ☐ Other Address (Fill out the required information below.)

Address*

City*	State*	ZIP Code*
Office Name*	Contact Phone*	

9. Healthcare Provider Consent

I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, 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. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. 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.

10. Healthcare Provider HIPAA and Telephone Consumer Protection Act (TCPA) Attestation

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 Pfizer Oncology medication.

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

HCP Signature*	**Date***

HCP Email Address (Provide if signing electronically):

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TO BE COMPLETED BY HCP

HCPs fax the **completed** form to 1-877-736-6506 or mail to: Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366. For questions, please call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

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11. Patient Information

*Required fields

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*

12. Diagnosis

Primary Diagnosis ICD-10*	Secondary Diagnosis ICD-10

Complete for Oral Medications

13. Prescription Information for Orals (Required if prescribing oral products.)

Please check the medicine prescribed and indicate strength & quantity.* Please provide complete directions and dosing information below.

- ☐ AROMASIN® (exemestane) 25 mg, 90-day supply
- ☐ BOSULIF® (bosutinib) _____ mg, 30-day supply
- ☐ BRAFTOVI® (encorafenib) ☐ 300 mg, ☐ 450 mg, ☐ Other: _____ ☐ 30-day supply, ☐ Other: _____
- ☐ DAURISMO™ (glasdegib sodium) _____ mg, 30-day supply
- ☐ EMCYT® (estramustine phosphate sodium) 140 mg, 90-day supply
- ☐ IBRANCE® (palbociclib) _____ mg, 28-day supply†

†Taken for 21 consecutive days followed by 7 days off treatment to comprise a complete cycle of 28 days.

- ☐ INLYTA® (axitinib) _____ mg, 30-day supply
- ☐ LORBRENA® (lorlatinib) _____ mg, 30-day supply
- ☐ MEKTOVI® (binimetinib) ☐ 45 mg, ☐ Other: _____ ☐ 30-day supply, ☐ Other: _____
- ☐ SUTENT® (sunitinib malate) _____ mg, ☐ 28-day supply ☐ 42-day supply
- ☐ TALZENNA® (talazoparib) _____ mg, 30-day supply
- ☐ VIZIMPRO® (dacomitinib) _____ mg, 30-day supply
- ☐ XALKORI® (crizotinib) _____ mg, 30-day supply

Directions/Dosing Instructions*:

Concomitant Medications*:	**Indicate number of refills*:**

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

Other Known Conditions*:

14. Prescription Signature

Special Note: New York prescribers must e-prescribe. To e-prescribe relevant products, see **Please Note** under Enrollment Checklist for HCP on page 4.

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.

_____ **HCP Signature* (Dispense As Written)**	_____ **HCP Signature* (Substitution Allowed)**	_____ **Date***

HCP Email Address (Provide if signing electronically):

15. Preferred Specialty Pharmacy (For commercially insured patients)

Preferred Specialty Pharmacy Name*	☐ Self-Dispensing Pharmacy

Preferred Specialty Pharmacy Address*

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.

Complete for Injectable Medications

16. Administering Provider Information (Administering/Overseeing Product Infusion) ☐ Check if same as Section 7

Name (First/MI/Last)*		Specialty*
NPI*	Group Tax ID*	State License*
Practice Name*		Office Contact*
Address*		
City*	State*	ZIP Code*
Phone*	Fax*	Email*

17. Dosing Information for Injectables* (Required if prescribing Provider-administered injectable products.)

☐ BESPONSA® (inotuzumab ozogamicin)	Vial Size	# of Vials	☐ IDAMYCIN® (idarubicin hydrochloride)	Vial Size	# of Vials
☐ CAMPTOSAR® (irinotecan hydrochloride)	Vial Size	# of Vials	☐ MYLOTARG™ (gemtuzumab ozogamicin)	Vial Size	# of Vials
☐ ELLENCE® (epirubicin hydrochloride)	Vial Size	# of Vials	☐ TORISEL® (temsirolimus)	Vial Size	# of Vials
Treatment start date			Frequency of treatment*		

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TO BE COMPLETED BY HCP

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Complete for Injectable Biosimilar Medications

18. Patient Information *Required fields

Patient Name (First/MI/Last)*	Patient DOB (mm/dd/yyyy)*

19. Diagnosis

Primary Diagnosis ICD-10*	Secondary Diagnosis ICD-10

The Prescribing Information for RUXIENCE™ does not include rheumatoid arthritis or pemphigus vulgaris. Support is not available for patients prescribed RUXIENCE™ to treat these conditions.

☐ Please check and sign here to confirm the patient does not have one of these conditions: _____

The Prescribing Information for ZIRABEV™ does not include ovarian, fallopian tube, or peritoneal cancer. Support is not available for patients prescribed ZIRABEV™ to treat these conditions.

☐ Please check and sign here to confirm the patient does not have one of these conditions: _____

20. Administering Provider Information (Administering/Overseeing Product Infusion) ☐ **Check if same as Section 7**

Name (First/MI/Last)*			Specialty*
NPI*	Group Tax ID*	State License*	DEA
Practice Name*		Office Contact*	
Address*			
City*		State*	ZIP Code*
Phone*	Fax*	Email*	

21. Billing Address for Co-Pay Payment from the Pfizer Oncology Together Co-Pay Savings Program for Injectables (If different from the HCP/Site of Care Information on page 4 or Administering Provider Information above.)

Practice Billing Office Name*	Practice Billing Office Contact*	
Practice Billing Office Address*		
City*	State*	ZIP Code*
Practice Billing Phone*	Fax*	Email*

22. Prescription Information for Injectables Biosimilars (Required if requesting assistance through Pfizer Patient Assistance Program.†)

☐ NIVESTYM® (filgrastim-aafi) Single-Dose Vial	300 mcg/mL _____	480 mcg/1.6 mL _____	
☐ NIVESTYM® (filgrastim-aafi) Prefilled Syringe	300 mcg/0.5 mL _____	480 mcg/0.8 mL _____	
☐ NYVEPRIA™ (pegfilgrastim-apgf) Prefilled Syringe	6 mg/0.6 mL _____		
☐ RETACRIT® (epoetin alfa-epbx) Single-Dose Vial (1 mL)	2000 U/mL _____	3000 U/mL _____	4000 U/mL _____
	10,000 U/mL _____	40,000 U/mL _____	
☐ RETACRIT® (epoetin alfa-epbx) 1 x 10 Multi-Dose Vials‡ ‡Doses for Pfizer Patient Assistance Program for RETACRIT® are only available in single-dose vials.	20,000 U/1 mL _____	20,000 U/2 mL _____	
☐ RUXIENCE™ (rituximab-pvvr) Single-Dose Vial	100 mg/10 mL _____	500 mg/50 mL _____	
☐ TRAZIMERA™ (trastuzumab-qyyp) Multi-Dose Vial	420 mg/vial _____		
☐ ZIRABEV™ (bevacizumab-bvzr) Single-Dose Vial	100 mg/4 mL _____	400 mg/16 mL _____	
Directions: Inject _____ mcg of NIVESTYM®	Frequency:	Quantity:	Refills:
Directions: Inject _____ mcg of NYVEPRIA™	Frequency:	Quantity:	Refills:
Directions: Inject _____ units of RETACRIT®	Frequency:	Quantity:	Refills:
Directions: Inject _____ mg of RUXIENCE™	Frequency:	Quantity:	Refills:
Directions: Inject _____ mg of TRAZIMERA™	Frequency:	Quantity:	Refills:
Directions: Inject _____ mg of ZIRABEV™	Frequency:	Quantity:	Refills:

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

Concomitant Medications*:

23. Prescription Signature (Required if requesting assistance through Pfizer Patient Assistance Program.†)

Special Note: New York prescribers must e-prescribe. To e-prescribe relevant products, see **Please Note** under Enrollment Checklist for HCP on page 4.

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.

_____	_____	_____
HCP Signature* (Dispense As Written)	**HCP Signature* (Substitution Allowed)**	**Date***

HCP Email Address (Provide if signing electronically):

†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.

Pfizer Oncology together™

HIPAA AUTHORIZATION FORM FOR THE DISCLOSURE OF PATIENT INFORMATION BY PERSONAL PHYSICIAN

To Physician

Please retain the original signed Authorization with the patient's records and provide a copy to the patient. You do not need to return this patient Authorization to Pfizer.

To Patient

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 identification of prior authorization requirements
  - Assisting with identification of requirements of your insurer for appeal of 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, the Pfizer Oncology Together 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 the Pfizer Oncology Together at P.O. Box 220366, Charlotte, NC 28222-0366 and call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. 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, the Pfizer Oncology Together, 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, Pfizer Oncology Together, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Oncology Together, 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 Pfizer Oncology Together at 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET.

Patient Signature (Patient or personal representative of patient)	
If personal representative, indicate relationship.	Date
Name (please print)	

