Pfizer Patient Assistance & Insurance Support Programs:

Enrollment Form for **Group B** Medicines

This enrollment form is for patients who would like to apply to receive any of the Group B medicines found below for free through the *Pfizer Patient Assistance Program*, or to receive help understanding and using their insurance benefits for the Group B medicine(s) they have been prescribed through the *Pfizer Insurance Support Program*. For help with any other Pfizer medicines, or to learn about Pfizer's other assistance programs, please call 844-989-PATH (7284) to speak with a Medicine Access Counselor (M-F, 8:00 am - 6:00 pm ET).

Do I Qualify for Assistance?

To qualify for assistance, you must:

- ☐ **Have been prescribed a Pfizer Group B medicine, including:**
  - ☐ **Aromasin®** *(exemestane tablets)*
  - ☐ **BeneFIX®** *(coagulation factor IX (recombinant))*
  - ☐ **Bosulif®** *(bosutinib)*
  - ☐ **Camptosar®** *(irinotecan HCl injection)*
  - ☐ **Ellence®** *(epirubicin hydrochloride injection)*
  - ☐ **Emcyt®** *(estramustine phosphate sodium capsules)*
  - ☐ **Ibrance®** *(palbociclib)*
  - ☐ **Idamycin PFS®** *(idarubicin hydrochloride for injection, USP)*
  - ☐ **Inlyta®** *(axitinib) tablets*
  - ☐ **Rapamune®** *(sirolimus)*
  - ☐ **Revatio®** *(sildenafil) tablets*
  - ☐ **Revatio®** *(sildenafil) for oral suspension*
  - ☐ **Sutent®** *(sunitinib malate)*
  - ☐ **Torisel®** *(temsirolimus) injection*
  - ☐ **Tygacil®** *(tigecycline) for injection*
  - ☐ **Vfend®** *(voriconazole)*
  - ☐ **Xalkori®** *(crizotinib)*
  - ☐ **Xyntha®** *(antihemophilic factor (recombinant) plasma/albumin-free)*
  - ☐ **Zinecard®** *(dexrazoxane for injection)*
- ☐ **Live in the United States or a U.S. territory**
- ☐ **Meet one of the following:**
  - ☐ **Have no prescription coverage, or not enough coverage to pay for your Pfizer medicine**
  - ☐ **Need help understanding your insurance coverage for the Group B medicine(s) you've been prescribed.**
- ☐ **Meet certain income limits** *(Income eligibility starts at 400% of the Federal Poverty Level and varies by product and household size. Income eligibility will be assessed upon receipt of your completed application.)*

How Can I Apply?

If you need immediate assistance with your Group B medicines, please call 844-989-PATH (7284).

Please follow the checklist below when submitting your application.

Remember:

Fill out and sign the patient section of this enrollment form.

Ask your prescriber to fill out and sign the prescriber section and complete the prescription/order section of this enrollment form.

- ☐ **Gather the following required documents:**
  - ☐ **Completed and signed enrollment form** *(pages 2-5)*
    *Note: Retain the HIPAA form on page 6 for your own records.
  - ☐ **A photocopy of one of the following documents that shows your total annual income:**
    - Previous year's federal tax return *(form 1040 or 1040EZ)*
    - Wage and tax statements *(W-2 forms)*
    - Two recent paycheck stubs
    - Social security, pension, or railroad retirement statements *(SSA-1099 or similar)*
    - Statements of interest, dividends, or other income *(1099-INT, 1099, 1099-DIV, or similar forms)*
- ☐ **Make a photocopy of your enrollment form and income documentation, as they typically will not be returned to you**
- ☐ **Have your prescriber fax (with an office cover page) or mail your application to:**

Pfizer Patient Assistance & Insurance Support Programs
P.O. Box 66976
St. Louis, MO 63166-6976
Fax: 800-708-3430

P.O. Box 66976, St. Louis, MO 63166-6976 T: 877-744-5675 F: 800-708-3430

PP-PAT-USA-0401 Printed in USA/August 2016 FRMRXP101

Enrollment Form for Group B Medicines: PATIENT SECTION

1 PATIENT INFORMATION

Patient Name: Gender: ☐ Male ☐ Female

Patient Address: City: State: Zip Code:

E-Mail: Telephone: DOB (MM/DD/YY):

Total Number of People Within Household *(including applicant)*: Total Annual Income for Entire Household:

Please submit documentation to support the financial information you've listed. Attached is:

☐ Most recent federal tax return ☐ W-2 form ☐ Other

Do you have prescription or insurance coverage? ☐ Yes *(If Yes, please complete section 2)* ☐ No *(If No, skip section 2)*

2 PRESCRIPTION COVERAGE AND INSURANCE INFORMATION

Is the Pfizer medicine you have been prescribed covered on your prescription or insurance plan? ☐ Yes ☐ No

Prescription Copay/Cost (if known):

Please check the one box that best describes your coverage type:

☐ Medicare ☐ Medicare Part D ☐ Medicaid ☐ Private/Employer ☐ State Insurance Marketplace ☐ Other

Primary Insurance Co. Name: Phone #:

Policy Holder Name: Policy Holder DOB:

Policy Holder SSN: Member ID or Policy #: Group #:

Prescription Card Name: Phone #:

RxBin #: PCN # Member ID or Policy #: Group #:

Secondary Insurance Co. Name: Phone #:

Policy Holder Name: Policy Holder DOB:

Policy Holder SSN: Member ID or Policy #: Group #:

Prescription Card Name: Phone #:

RxBin #: PCN # Member ID or Policy #: Group #:

3 SUTENT IN Touch, a free support program for patients starting treatment *(For Sutent patients only)*

☐ By checking this box, I agree that the information I provide will be used by Pfizer and parties acting on its behalf to send me the materials I requested and other helpful information and updates on SUTENT and/or my condition as well as related treatments, products, offers and services, including information about the SUTENT IN Touch Call Center. Pfizer may also use my information to communicate with me and my health care provider in relation to my treatment.

4 PATIENT PRIVACY AND CONSENT *(Read and sign below)*

The information you provide will be used by Pfizer, 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, and/or to send you materials and other helpful information and updates relating to Pfizer programs. 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 Pfizer's assistance programs.
- 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.

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 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 Prescriber so that my Prescriber may share health information about me with Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc.

Signature of Patient *(Parent or guardian, if under 18 years of age)* X Date:

The *Pfizer Patient Assistance Program* is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™.
The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

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Enrollment Form for Group B Medicines: PRESCRIBER SECTION

1 PRESCRIPTION/ORDER INFORMATION *(Complete for the following products only)*

- ☐ **Sutent:** _____ mg, 28 day supply
- ☐ **Sutent:** _____ mg, 42 day supply
- ☐ **Aromasin:** 25 mg, 90 day supply
- ☐ **Xalkori:** 250 mg, 30 day supply
- ☐ **Xalkori:** 200 mg, 30 day supply
- ☐ **Inlyta:** _____ mg, 30 day supply
- ☐ **Bosulif:** _____ mg, 30 day supply
- ☐ **Emcyt:** _____ mg, 90 day supply

- ☐ **Vfend:** 50 mg, 60 day supply
- ☐ **Vfend:** 200 mg, 60 day supply
- ☐ **Revatio:** 20 mg, 90 day supply
- ☐ **Revatio Oral Suspension:** 10 mg, 90 day supply
- ☐ **Rapamune:** .5 mg, 90 day supply
- ☐ **Rapamune:** 1 mg, 90 day supply
- ☐ **Rapamune:** 2 mg, 90 day supply
- ☐ **Rapamune Oral Solution:** 1 mg, 90 day supply
- ☐ **Ibrance:** 75 mg, 28 day supply
- ☐ **Ibrance:** 100 mg, 28 day supply
- ☐ **Ibrance:** 125 mg, 28 day supply
- **Elelyso:** Total dose _____ units every _____ weeks, 28 day supply

- ☐ **Xyntha Antihemophilic Factor, Plasma/Albumin-Free**
- ☐ **BeneFIX Coagulation Factor IX**

☐ 250 IU ☐ 500 IU ☐ 1,000 IU ☐ 2,000 IU ☐ 3,000 IU ☐ Monthly dosage: _____ IU

PATIENT INFORMATION

First Name: **Last Name:**

Date of Birth: **Phone #:**

Patient Address: **City:** **State:** **Zip Code:**

Shipping Address *(If different than above)*: **City:** **State:** **Zip Code:**

PRESCRIPTION *(For full prescribing information, go to www.pfizer.com)*

Directions: **Quantity:** _____ **Refill:** _____ times

Drug Allergies: ○ Yes ○ No **If yes, please specify:**

Patient's Concurrent Medications:

Prescribing Physician (Please Print):

Prescriber Signature: X **Date:**

Circle One: **Dispense as Written** **May Substitute**

Special Note: *In addition to completing this section, New York prescribers must submit a prescription on an original NY state prescription blank. Prescribers in all other states only need to submit a state-specific blank if it's required in their state, and the application is mailed.*

2 TRANSPLANT HISTORY *(Complete for Rapamune only)*

Date of Transplant (MM/DD/YY): **Medicare Part A Effective Date (MM/DD/YY):**

Medicare Approved Facility: ○ Yes ○ No

3 PHYSICIAN ADMINISTERED PRODUCTS *(Complete for the following IV products only)*

Please check the appropriate Pfizer product *(For full prescribing information, go to www.pfizer.com)*

- ☐ **Torisel®** ***(temsirolimus)*** **injection**
- ☐ **Camptosar®** ***(irinotecan hydrochloride)*** **injection**
- ☐ **Ellence®** ***(epirubicin hydrochloride)*** **injection**
- ☐ **Idamycin®** ***(idarubicin hydrochloride)*** **injection**
- ☐ **Zinecard®** ***(dexrazoxane)*** **injection**

TREATMENT INFORMATION *(Indicate amount of Pfizer product requested for patient assistance)*

Patient Name:

Treatment Start Date: **Dosage:**

Dosing Regimen:

Vial Size/# of Vials:

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PP-PAT-USA-0401 Printed in USA/August 2016 FRMRXP101

Enrollment Form for Group B Medicines: PRESCRIBER SECTION

4 Prescriber Information *(To be completed by the prescriber)*

Prescriber Name & Title:

NPI #: **Tax ID #:**

State License #: **DEA #:**

Office Contact Name:

Name of Facility:

Facility Address:

City: **State:** **Zip Code:**

Phone: **Fax:**

Ship to: ☐ Prescriber ☐ Patient

Prescriber E-mail Address:

Supervising Physician Name and State License # (if applicable):

Please provide diagnosis and specific ICD-10 code:

5 PRESCRIBER PRIVACY AND CONSENT *(Read and sign below)*

The information you provide will be used by 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 Pfizer's assistance programs, to communicate with you about your experience with Pfizer's assistance programs, 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 certify that the information provided is current, complete, and accurate to the best of my knowledge.
- 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 its 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.
- 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 Pfizer 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 Form so that I may share patient health information with Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation Inc.

Signature of Prescriber X **Date:**

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HIPAA Authorization Form for the Disclosure of Patient Information by Express Scripts, Inc.
FOR PFIZER INC AND THE PFIZER PATIENT ASSISTANCE FOUNDATION, INC.
PFIZER ASSISTANCE PROGRAMS

PLEASE SUBMIT THIS SIGNED FORM WITH YOUR COMPLETED APPLICATION

To the Patient: This Authorization relates to information shared between you and Express Scripts, Inc. as the specialty pharmacy provider contracted by Pfizer Inc to provide enrollment and pharmacy fulfillment services for Pfizer's assistance programs. The *Pfizer Patient Assistance Program* is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™, Inc.

Pfizer Inc and the Pfizer Patient Assistance Foundation, Inc. offers patient assistance programs (the "Program") to help patients who meet certain requirements to obtain certain Pfizer medicines at no cost. In order to administer your participation in the Program if you are accepted, Pfizer Inc along with its affiliates, agents, contractors, and representatives who work on behalf of Pfizer for this Program, as well as your doctors and other relevant health care treatment providers, need to obtain certain information about you from the specialty pharmacy administering the program, Express Scripts, Inc. **Please complete this Authorization, sign and date it, and return the original with your application. Please also keep a copy for your records.**

I request and authorize that the specialty pharmacy administering the Program, Express Scripts, Inc. ("Specialty Pharmacy") disclose to Pfizer Inc, including affiliates, agents, contractors, and representatives who work on behalf of Pfizer for this Program (together, "Pfizer"), as well as my doctors and other relevant health care treatment providers (together, "Providers"), information about me and my medical condition ("Protected Health Information"), which is necessary to administer my participation in the Program if I am accepted, to account for my withdrawal if I decide to stop participating in this Program, and to evaluate patient satisfaction and the Program's overall effectiveness.

The Protected Health Information that can be given under this authorization may include, among other information I provide to my Specialty Pharmacy, my name and birth date, my address and telephone number, my social security number, financial information about me, information about my health benefits or health insurance coverage, information about my prescriptions, and information on my medical condition, as necessary. Further, I understand and consent to Pfizer monitoring and recording calls between me and my Specialty Pharmacy as they relate to my participation in the Program for quality control or training purposes. I also understand that my Specialty Pharmacy may receive direct and/or indirect remuneration from Pfizer in connection with administering the Program.

I understand that my Protected Health Information will not be used or disclosed by my Specialty Pharmacy for any purposes other than as described here, unless permitted or required by law, or unless my Protected Health Information is de-identified in accordance with applicable standards.

I understand that the disclosed Protected Health Information may be re-disclosed in accordance with law and may no longer be protected by the federal privacy standards. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. If my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed under these circumstances and provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Authorization or participate in the Program. My choice about whether to sign will only impact the optional support services being provided under the Program. If I refuse to sign this Authorization, or revoke my Authorization later, I understand that this means I will not be able to receive the optional support services under the Program. I also understand that signing this Authorization does not guarantee that I will be accepted into the Program.

I know that I can cancel (revoke) this Authorization at any time by mailing a letter to my Specialty Pharmacy at P.O. Box 66976, St. Louis, MO 63166-6976 or by calling 877-744-5675. If I cancel this Authorization, then my Specialty Pharmacy will stop providing Pfizer and my Providers with information about me. However, I cannot cancel actions that have already been taken by relying on my authorization.

This authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medicines under the Program, whichever is later, or as required by state law.

Patient or Personal Representative of Patient *{If personal representative, indicate authority to sign on behalf of Patient (if applicable)}*

Name (please print) _____

Signature _____

Date _____

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HIPAA Authorization Form for the Disclosure of Patient Information by Personal Physician

FOR PFIZER INC AND THE PFIZER PATIENT ASSISTANCE FOUNDATION, INC. PFIZER ASSISTANCE PROGRAMS

DO NOT SUBMIT THIS FORM WITH YOUR APPLICATION—IT IS FOR PATIENT AND PRESCRIBER RECORDS ONLY

To the Patient: Pfizer Inc and the Pfizer Patient Assistance Foundation, Inc. offer patient assistance programs (the "Program") to help patients who qualify obtain certain Pfizer medicines at no cost. In order to determine your eligibility for the Program and to administer your participation in the Program if you are accepted, Pfizer, along with its affiliated companies and contractors who administer the Program, need to obtain certain information about you from your physician (who is also called your "Doctor" in this form). **Please complete this Authorization, sign and date it, and return it to your doctor.**

To the 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.**

I request and authorize my Doctor, _____, to give Pfizer Inc, including representatives and contractors who work on behalf of Pfizer in this Program, and including Express Scripts, Inc. (collectively, "Pfizer"), my protected health information, including but not limited to information about my medical condition and treatments, which is necessary to determine my eligibility for the Program and for my continuing participation in the Program if I am accepted, to administer the Program, to account for my withdrawal if I decide to stop participating in this Program, and to evaluate patient satisfaction and the Program's overall effectiveness. The type of information that can be given under this authorization may include:

- My name and birth date
- My address and telephone number
- My social security number
- Financial information about me
- Information about my health benefits or health insurance coverage
- Information on my medical condition, as necessary

I understand that I may refuse to sign this authorization and that it is strictly voluntary. Further, I understand that my Doctor may not condition the provision of my treatment on my signing this authorization.

I know that I can cancel (revoke) this authorization at any time by writing to my Doctor at _____. If I cancel this authorization, then my Doctor will stop providing Pfizer, and its representatives, with information about me. However, I cannot cancel actions that have already been taken by relying on my authorization.

I understand that once my Doctor gives Pfizer information about me based on this authorization, federal privacy laws may not prevent Pfizer from further disclosing my information. I also understand that signing this authorization does not guarantee that I will be accepted into a Pfizer patient assistance program.

This authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medicines under the Program, whichever is later, or as required by state law.

Patient or Personal Representative of Patient *{If personal representative, indicate authority to sign on behalf of Patient (if applicable)}*

Signature _____

Date _____

Name ***(please print)*** _____

Please return the signed form to your Doctor. You are entitled to a copy for your records.