



ENROLL ONLINE: Patients visit [pfizeroncologypatientenroll.com](https://pfizeroncologypatientenroll.com) and HCPs visit [pfizeroncologytogether-portal.com](https://pfizeroncologytogether-portal.com) (registration required).

Please complete and send pages 1-8 to Pfizer Oncology Together.

UPLOAD COMPLETED FORMS/DOCUMENTS VIA  
[patientsupportnow.org](https://patientsupportnow.org) Enter code: 8777366506

FAX COMPLETED FORMS  
 TO 1-877-736-6506

MAIL TO Pfizer Oncology Together,  
 PO Box 220366, Charlotte, NC 28222-0366

### Patient Support Enrollment Form for Injectables

- Pfizer Oncology Together Co-pay Savings Program for Injectables – STOP:** Do not complete this form. Visit [PfizerCopoly.com](https://PfizerCopoly.com) to apply for the Co-Pay Savings Program online.
- Benefits Verification** – We'll determine the patient's health insurance coverage and out-of-pocket costs and fax a summary of benefits to the HCP office.

#### For ELREXFIO™ Only

- Patient Access Navigator**  
 Patient Access Navigators work one-on-one with patients and their care team to provide access and reimbursement support and coordinate treatment logistics.

#### For BESPONSA and MYLOTARG Only

- New Uninsured or Government Underinsured Patient:**  
**Pfizer Patient Assistance Program (PAP)\*** – For patients who are uninsured or are government underinsured and understand co-pay requirement but cannot afford co-pay and have been prescribed a medicine available through the PAP.
- Requesting re-enrollment in the PAP**

#### PAP and Co-pay Only

- BESPONSA® (inotuzumab ozogamicin)
- MYLOTARG™ (gemtuzumab ozogamicin)

#### Reimbursement Support and Co-pay Only

- ELREXFIO™ (elranatamab-bcmm)

#### Co-pay Only

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



- For RUXIENCE and ZIRABEV, the Prescribing Information does not include all of the indications of the original manufacturer's product. Please see Section 14 (Page 7) to confirm and acknowledge program limitations.
- For ELREXFIO: Healthcare Providers, Site of Care and/or Specialty Pharmacy must be Risk Evaluation and Mitigation Strategy (REMS)-certified prior to ordering and/or dispensing medication.

### Patient Eligibility for the Pfizer Patient Assistance Program

To qualify for free medicine†, the patient must meet the criteria below:

- Have a valid prescription for a Pfizer medicine available through the PAP
- Have an FDA approved diagnosis for the requested medicine(s) as confirmed by the HCP signing and dating Section 15 of this form (if applicable)
- Have a gross annual household income at or below 300% of the Federal Poverty Level
- Reside in the U.S. or an applicable U.S. territory
- Be treated by a healthcare provider licensed in the U.S. or an applicable U.S. territory

†Eligibility criteria are subject to change at any time.

- Meet one of the following:
  - Have no insurance coverage
  - Have government insurance, understand co-pay requirements as a result of the completion of a Benefit Investigation, and are unable to afford their insurer required co-pay
  - Have been denied coverage by your government insurer for the Pfizer medicine listed above (after at least one unsuccessful appeal to your insurer)

**IMPORTANT NOTE: Commercially insured patients are not eligible to enroll in the Pfizer Patient Assistance Program, even if the medication is not covered by the commercial insurance plan.**

### Enrollment Checklist for Patients



**IMPORTANT NOTE:** The patient must sign and date all applicable sections of the form unless they are incapacitated and unable to sign or they are under 18 years of age.

Patients/caregivers can complete, sign, and submit their portion of the Enrollment form online by visiting: [pfizeroncologypatientenroll.com](https://pfizeroncologypatientenroll.com)

OR complete this form using the following instructions:

Pages 1 through 5 should be completed by the patient or caregiver. When completing these pages, keep the following points in mind:

- Complete **Sections 1 and 2** ensuring that you include the Medicare Part D address if you have a Part D plan AND include copies of the front and back of all medical and pharmacy insurance cards.
- Sign and date **Section 3**.
- If applying for financial assistance:
  - Complete **Section 4** and either sign/date **Section 5** providing consent for electronic income verification OR you are required to submit proof of income documentation for your entire household (examples of acceptable documents in **Section 4**).
  - Sign and date **Section 6** and check the box if you want to sign up to receive PAP refill reminders and be able to request PAP refills via text message.
- All patients must sign and date the Patient Authorization to Share Health Information on Page 5.
- Patients must understand their insurer required co-pay prior to requesting assistance through the PAP.

### Enrollment Checklist for HCP

HCPs can complete and submit Enrollment Forms online at [pfizeroncologytogether-portal.com](https://pfizeroncologytogether-portal.com) OR complete this form using the instructions below: Pages 6 through 8 should be completed by the healthcare provider. Fill out every section for all patient enrollment requests and:

- Complete **Sections 9** (a Benefit Verification/Pharmacy Claim must be completed to determine the patient's insurance required co-payment before requesting assistance), **10**, and **11** (if the patient is applying for the PAP)
- Sign and date **Section 12**.
- Complete **Sections 13 and 14**.
- If your patient is applying for PAP, sign and date **Section 15** only if applicable to your patient.
- Sign and date **Section 17**.
- Complete the prescription in **Section 18** and sign and date **Section 19**.
- Read certification statement in **Section 21**.

\*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.

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](https://www.pfizer.com/privacy).



Patients/caregivers can complete, sign, and submit their portion of the Enrollment form online by visiting: [pfizeroncologypatientenroll.com](https://pfizeroncologypatientenroll.com)  
OR complete this form and submit using one of the methods below.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. 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](https://www.pfizer.com/privacy).

Please complete and send pages 1-8 to Pfizer Oncology Together.



UPLOAD COMPLETED FORMS/DOCUMENTS VIA  
[patientsupportnow.org](https://patientsupportnow.org) Enter code: 8777366506



FAX COMPLETED FORMS  
TO 1-877-736-6506



MAIL TO Pfizer Oncology Together,  
PO Box 220366, Charlotte, NC 28222-0366

## HCP Information

\*Required fields

HCP Name (First/MI/Last)\*

Contact Phone\*

## 1 Patient Information

Patient Name (First/MI/Last)\*

Patient DOB (mm/dd/yyyy)\*

Sex\*  Male  Female  Other

Street Address\*

City\*

State\*

ZIP Code\*

Phone\*

 H  M  W

Email Address

Best Time to Contact  Morning  Afternoon  Evening

Preferred Language (if not English)

Caregiver Name

Caregiver Relationship

Caregiver Phone

 H  M  W

## 2 Patient Insurance Information

IMPORTANT NOTE: Commercially Insured Patients are not eligible for the Pfizer Patient Assistance Program.†

Is the Pfizer medication covered by either medical or prescription insurance?\*

 Yes  No

If yes, what is the co-pay amount?\*\$

If you are applying for the PAP, this information is required.

## Primary Insurance

## Secondary Insurance

## Prescription Insurance

Check Insurance Type\*:

 None (Skip to Section 3) Commercial  Medicare  
 Medicaid  Other Commercial  Medicare  
 Medicaid  Other Commercial  Medicare  
 Medicaid  Other

Insurance Name\*

Insurer's Phone\*

Policy/Medicare Beneficiary ID #\*

Group #\*

Policyholder Name\*

Relationship to Patient

Policyholder DOB

BIN #\*

PCN #\*

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

†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.



Patients/caregivers can complete, sign, and submit their portion of the Enrollment form online by visiting: [pfizeroncologypatientenroll.com](https://pfizeroncologypatientenroll.com)  
OR complete this form and submit using one of the methods below.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. 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](https://www.pfizer.com/privacy).

Please complete and send pages 1-8 to Pfizer Oncology Together.



UPLOAD COMPLETED FORMS/DOCUMENTS VIA  
[patientsupportnow.org](https://patientsupportnow.org) Enter code: 8777366506



FAX COMPLETED FORMS  
TO 1-877-736-6506



MAIL TO Pfizer Oncology Together,  
PO Box 220366, Charlotte, NC 28222-0366

### 3 Patient Financial Information Required if requesting financial assistance services, including but not limited to the Pfizer Patient Assistance Program.†

\*Required fields

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

Total Number of People Within Household (including applicant)\*

Total Gross Annual Household Income\* \$

If you choose not to opt in for Electronic Income Verification in Section 4, you must submit documentation for household to support the financial information you've listed. Attached is:  Most recent federal tax return (IRS 1040/1040-SR form form)  W-2 form  Other

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

I, the applicant named 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 and dating 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 below 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 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 and date certifies that I have read and understand the above statements and agree to the outlined terms.

SIGN

\_\_\_\_\_  
Patient Signature\* (Patient or patient representative)

\_\_\_\_\_  
Patient representative name (please print)

\_\_\_\_\_  
Date\*

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

Court Appointed  Parent/Guardian  Power of Attorney, including authority to make healthcare decisions  Other \_\_\_\_\_

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

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 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 and dating 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, 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 Patient 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 Inc., and the Pfizer Patient Assistance Foundation™ Inc.

**Permission for Refill Reminder text communications:**

**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](https://www.pfizer.com/privacy). Please enter the number you would like to enroll for texting \_\_\_\_\_

SIGN

\_\_\_\_\_  
Patient Signature\* (Patient or patient representative)

\_\_\_\_\_  
Patient representative name (please print)

\_\_\_\_\_  
Date\*

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

Court Appointed  Parent/Guardian  Power of Attorney, including authority to make healthcare decisions  Other \_\_\_\_\_

†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.



Patients/caregivers can complete, sign, and submit their portion of the Enrollment form online by visiting: [pfizeroncologypatientenroll.com](https://pfizeroncologypatientenroll.com)  
OR complete this form and submit using one of the methods below.

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. 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](https://www.pfizer.com/privacy).

Please complete and send pages 1-8 to Pfizer Oncology Together.



UPLOAD COMPLETED FORMS/DOCUMENTS VIA  
[patientsupportnow.org](https://patientsupportnow.org) Enter code: 8777366506



FAX COMPLETED FORMS  
TO 1-877-736-6506



MAIL TO Pfizer Oncology Together,  
PO Box 220366, Charlotte, NC 28222-0366

## 6 Patient Consent to Receive Communications This is required for all services excluding Patient Access Navigator Opt in. \*Required fields

By signing and dating below, 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.

Yes  No

### SIGN

\_\_\_\_\_  
Patient Signature\* (Patient or patient representative)

\_\_\_\_\_  
Patient representative name (please print)

\_\_\_\_\_  
Date\*

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

Court Appointed  Parent/Guardian  Power of Attorney, including authority to make healthcare decisions  Other \_\_\_\_\_

## 7 Personalized Patient Support Program Opt-In (Optional – For ELREXFIO Only)

When you enroll in Pfizer Oncology Together, you have the option to be contacted by a Pfizer Patient Access Navigator who can help you understand your insurance benefits and navigate the process to access your prescribed medication. Pfizer Patient Access Navigators are field-based employees of Pfizer Oncology and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. Pfizer Patient Access Navigators are very familiar with access and reimbursement requirements for ELREXFIO™ (elranatamab-bcmm), and the Pfizer Patient Access Navigator assigned to you will coordinate with Pfizer Oncology Together and you on your journey to starting therapy (although you will still need to contact Pfizer Oncology Together directly if you are seeking financial assistance). Working with a Pfizer Patient Access Navigator is optional. Even if you choose not to opt in for this support, you may still access all Patient Support Activities you are eligible for by working with a case manager at Pfizer Oncology Together.

By checking this box, I request Pfizer Patient Access Navigator support and agree to receive telephonic communications from the Pfizer Patient Access Navigator assigned to my case as 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 support from and communications with the Pfizer Patient Access Navigator at any time by contacting Pfizer Oncology Together at 1-877-744-5671.

## 8 Pfizer Oncology Together Co-Pay Savings Program for Injectables (for commercially-insured patients only)



Go to [pfizercopay.com](https://pfizercopay.com) and select “Patient” or check the appropriate boxes below if you are ONLY requesting enrollment in the Pfizer Oncology Together Co-Pay Savings Program for Injectables for the following products: ELREXFIO, 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 when my healthcare provider submits the co-pay claim. 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 180 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 am not (nor is my spouse) 65 years of age or older and retired.

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 do not receive health insurance through the military.

By checking this box, I confirm that I am eligible to participate in this program and agree to the [Terms and Conditions](#) specified here. Please agree to the Terms and Conditions before proceeding.

If you have questions relating to your eligibility for the Pfizer Oncology Together Co-Pay Savings Program for Injectables, you can contact Pfizer Oncology Together and provide your commercial insurance information to verify eligibility. Terms and Conditions apply. For full Terms and Conditions for injectable products, please see [PfizerCopay.com/TC](https://PfizerCopay.com/TC). Pfizer understands that your personal and health information is private and will only use your information in accordance with our [Privacy Policy](#). The information you provide will only be used by Pfizer and parties acting on its behalf to send you the materials you requested as well as other helpful product and/or related product information, disease state information, offers, and services.

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](http://www.pfizer.com/privacy).

- ✔ **To Patient:** Read, sign, and date the Patient Authorization form. This is required to request assistance.
- ✔ **To HCP:** Send to Pfizer Oncology Together. Submit forms and documents via [patientsupportnow.org](http://patientsupportnow.org). Enter code: 8777366506. Fax to: 1-877-736-6506 or Mail to: Pfizer Oncology Together, PO Box 220366, Charlotte, NC 28222-0366.

By signing and dating 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
- Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities
- Providing me with financial assistance resources and information if I’m eligible
- Providing me with disease management and other educational materials, as well as information about Pfizer’s products, services, and programs, and may

include sending me surveys about my experience with Pfizer’s products, services, and programs

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their 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 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. 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 I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact Pfizer Oncology Together at P.O. Box 220366, Charlotte, NC 28222-0366 or at 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 will receive a signed copy of this form.

**SIGN** Patient Signature (Patient or patient representative)

Patient representative name (please print)

Date

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

- Court Appointed     Parent/Guardian     Power of Attorney, including authority to make healthcare decisions     Other \_\_\_\_\_



HCPs can complete and submit Enrollment Forms online at: [pfizeroncologytogether-portal.com](https://pfizeroncologytogether-portal.com) (registration required).

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. 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](https://www.pfizer.com/privacy).

Please complete and send pages 1-8 to Pfizer Oncology Together.



UPLOAD COMPLETED FORMS/DOCUMENTS VIA  
[patientsupportnow.org](https://patientsupportnow.org) Enter code: 8777366506



FAX COMPLETED FORMS  
TO 1-877-736-6506



MAIL TO Pfizer Oncology Together,  
PO Box 220366, Charlotte, NC 28222-0366

**IMPORTANT NOTE:** Commercially insured patients are not eligible to enroll in the Pfizer Patient Assistance Program, even if the medication is not covered by the commercial insurance plan.

## 9 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?* <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is their co-pay amount?*	
IMPORTANT NOTE: If the patient is commercially insured, they are not eligible for assistance through the Pfizer Patient Assistance Program.		\$	
Has your HCP office or a pharmacy completed a Benefit Investigation/ Pharmacy Claim for the requested product?* <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, Stop. This is required to be completed prior to requesting PAP enrollment.		Does your patient understand their insured required co-pay and have they directly communicated that they are unable to afford this? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## 10 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*: <input type="checkbox"/> Provider's office <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Other <input type="checkbox"/> N/A				
Contact Name*			Contact Phone*	

## 11 Shipping Information for Pfizer Patient Assistance Program<sup>†</sup> Patients Required if requesting assistance through the Pfizer Patient Assistance Program.<sup>†</sup>

Patient Name*				
Ship To*:		<input type="checkbox"/> Administering Provider Address (Section 16)		
<input type="checkbox"/> Patient Address (Section 1)		<input type="checkbox"/> Other Address (Fill out the required information below.)		
<input type="checkbox"/> HCP/Site of Care Address (Section 10)				
Address*				
City*		State*		ZIP Code*
Office Name*			Contact Phone*	

## 12 Pfizer Patient Assistance Program<sup>†</sup> Healthcare Provider Consent Required if requesting assistance through the Pfizer Patient Assistance Program.<sup>†</sup>

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™ Inc. 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 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 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™.

**SIGN**

HCP Signature\*

Date\*

<sup>†</sup>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.



HCPs can complete and submit Enrollment Forms online at: [pfizeroncologytogether-portal.com](https://pfizeroncologytogether-portal.com) (registration required).

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. 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](https://www.pfizer.com/privacy).

Please complete and send pages 1-8 to Pfizer Oncology Together.



UPLOAD COMPLETED FORMS/DOCUMENTS VIA  
[patientsupportnow.org](https://patientsupportnow.org) Enter code: 8777366506



FAX COMPLETED FORMS  
TO 1-877-736-6506



MAIL TO Pfizer Oncology Together,  
PO Box 220366, Charlotte, NC 28222-0366

### 13 Patient Information Required

\*Required fields

Patient Name (First/MI/Last)\*

Patient DOB (mm/dd/yyyy)\*

### 14 Diagnosis\* Required

Primary Diagnosis ICD-10\*

Secondary Diagnosis ICD-10

The Prescribing Information for RUXIENCE (rituximab-pvvr) does not include pemphigus vulgaris. Support is not available for patients prescribed RUXIENCE to treat this condition.

Please check and sign here to confirm the patient does not have this condition: \_\_\_\_\_

The Prescribing Information for ZIRABEV (bevacizumab-bvzr) does not include hepatocellular carcinoma. Support is not available for patients prescribed ZIRABEV to treat this condition.

Please check and sign here to confirm the patient does not have this condition: \_\_\_\_\_

### 15 On-Label Certification This is required for PAP and, if not signed, the patient is not eligible to be considered for the Pfizer Patient Assistance Program.†

I certify that my decision to prescribe this Pfizer product is based solely on my independent clinical judgment, and I have prescribed the product for an FDA-approved indication consistent with all FDA requirements and labeling.

**SIGN**

HCP Signature\*

Date\*

### 16 Administering Provider Information (Administering/Overseeing Product Infusion) Check if same as Section 10

Name (First/MI/Last)\*

Specialty\*

NPI\*

Group Tax ID\*

State License\*

DEA

Practice Name\*

Office Contact\*

Address\*

City\*

State\*

ZIP Code\*

Phone\*

Fax\*

Email\*

### 17 Healthcare Provider Consent and HIPAA and Telephone Consumer Protection Act (TCPA) Attestation This is required for all services.

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.

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 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.

Yes  No

**SIGN**

HCP Signature\*

Date\*

†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.



HCPs can complete and submit Enrollment Forms online at: [pfizeroncologytogether-portal.com](https://pfizeroncologytogether-portal.com) (registration required).

Questions? Call 1-877-744-5675, Monday–Friday, 8 AM–8 PM ET. 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](https://www.pfizer.com/privacy).

Please complete and send pages 1-8 to Pfizer Oncology Together.



UPLOAD COMPLETED FORMS/DOCUMENTS VIA  
[patientsupportnow.org](https://patientsupportnow.org) Enter code: 8777366506



FAX COMPLETED FORMS  
TO 1-877-736-6506



MAIL TO Pfizer Oncology Together,  
PO Box 220366, Charlotte, NC 28222-0366

### 18 Patient Information

Required if requesting assistance through the Pfizer Patient Assistance Program\* or transferring the prescription to a pharmacy (as needed).

\*Required fields

Patient Name (First/MI/Last)\*

Patient DOB (mm/dd/yyyy)\*

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

Concomitant Medications\*:

Other Known Conditions\*:

DRUG NAME	VIAL SIZE	# OF VIALS	REFILLS	TREATMENT START DATE	FREQUENCY OF TREATMENT	DIRECTIONS
<input type="checkbox"/> BESPONSA (inotuzumab ozogamicin)						
<input type="checkbox"/> MYLOTARG (gemtuzumab ozogamicin)						

### 19 Prescription Signature

Required if requesting assistance through the Pfizer Patient Assistance Program\* or transferring the prescription to a pharmacy (as needed).

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 (if received) to the appropriate pharmacy.

**SIGN**

HCP Signature\* (Dispense As Written)

HCP Signature\* (Substitution Allowed)

Date\*

**Please Note:** If you wish to e-prescribe and you cannot find AmeriPharm (NPI number–1073692745; NCPDP number–4351968), please search for MedVantx under retail pharmacies (NPI number–1235371535; NCPDP number–4354180). The prescription will be sent to the same place. **New York prescribers must e-prescribe.**

### 20 Prescription Information for Injectables (Reimbursement Support\* and Co-Pay Only)

<input type="checkbox"/> ELREXFIO (elranatamab-bcmm) Single-Dose Vial (40 mg/mL) Healthcare Providers, Site of Care and/or Specialty Pharmacy must be Risk Evaluation and Mitigation Strategy (REMS)-certified prior to ordering and/or dispensing medication	<input type="checkbox"/> 44 mg/1.1 mL	<input type="checkbox"/> 76 mg/1.9 mL		
<input type="checkbox"/> NIVESTYM (filgrastim-aafi) Single-Dose Vial	<input type="checkbox"/> 300 mcg/mL	<input type="checkbox"/> 480 mcg/1.6 mL		
<input type="checkbox"/> NIVESTYM (filgrastim-aafi) Prefilled Syringe	<input type="checkbox"/> 300 mcg/mL	<input type="checkbox"/> 480 mcg/0.8 mL		
<input type="checkbox"/> NYVEPRIA (pegfilgrastim-apgf) Prefilled Syringe	<input type="checkbox"/> 6 mg/0.6 mL			
<input type="checkbox"/> RETACRIT (epoetin alfa-epbx) Single-Dose Vial (1 mL)	<input type="checkbox"/> 3000 U/mL	<input type="checkbox"/> 4000 U/mL	<input type="checkbox"/> 10,000 U/mL	<input type="checkbox"/> 40,000 U/mL
<input type="checkbox"/> RUXIENCE (rituximab-pvvr) Single-Dose Vial	<input type="checkbox"/> 100 mg/10 mL	<input type="checkbox"/> 500 mg/50 mL		
<input type="checkbox"/> TRAZIMERA (trastuzumab-qyyp) Multi-Dose Vial	<input type="checkbox"/> 150 mg/vial	<input type="checkbox"/> 420 mg/vial		
<input type="checkbox"/> ZIRABEV (bevacizumab-bvzr) Single-Dose Vial	<input type="checkbox"/> 100 mg/4 mL	<input type="checkbox"/> 400 mg/16 mL		

### 21 Healthcare Provider Certification for products prescribed in Section 20

By submitting this form, 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.

\*For ELREXFIO only

\*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.