Pfizer Oncology together™

PATIENT REIMBURSEMENT SUPPORT SERVICES ENROLLMENT FORM

UPLOAD online at **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

PATIENTS CAN COMPLETE THIS FORM ONLINE at PfizerOncologyPatientEnroll.com

QUESTIONS? Call 1-877-744-5675, M–F, 8 AM–8 PM
JUST LOOKING FOR CO-PAY ASSISTANCE? Visit pfizercopay.com

INJECTABLES

Reimbursement Support and/or Co-pay

☐ ELREXFIO™ (elranatamab-bcmm)
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. See **Section 5** for opt-in information.

Co-pay Only

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

Benefits Investigation – When a payer coverage issue requires research ONLY

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

ORALS

Benefits Investigation ☐ **To obtain in-network Specialty Pharmacy (if unknown)** ☐ **When a payer coverage issue requires research ONLY**

☐ BOSULIF® (bosutinib)
☐ BRAFTOVI® (encorafenib)
☐ DAURISMO™ (glasdegib sodium)
☐ IBRANCE® (palbociclib)
☐ INLYTA® (axitinib)
☐ LORBRENA® (lorlatinib)
☐ MEKTOVI® (binimetinib)
☐ TALZENNA® (talazoparib)
☐ VIZIMPRO® (dacomitinib)
☐ XALKORI® (crizotinib)

FOR PATIENTS – Complete the following sections; then, read, sign, and date (where applicable) the required authorization and consents. Missing information or consents may cause delays in filling your prescription and signing you up for the Pfizer Oncology Together™.

HCP First Name* _____ **HCP Last Name*** _____ **Contact Phone*** _____

1 PATIENT INFORMATION (*REQUIRED)

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

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

Address* _____

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

Primary Phone* _____ ☐ H ☐ M ☐ W

Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Preferred Language if not English: _____

Email _____

Caregiver Name _____ Phone _____ Email _____

2 INSURANCE INFORMATION

Insurance Type*: ☐ **Commercial** ☐ **Government** ☐ **Medicare Part D** ☐ **Medicare A/B only** ☐ **Medicaid** ☐ **VA Benefits**
☐ **Other** _____ ☐ **None†**

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

†If None is selected, patients can fill out the Pfizer Patient Assistance Program† 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.

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FOR PATIENTS

3 PATIENT PRIVACY NOTICE AND CONSENT TO PROCESS HEALTH INFORMATION (*REQUIRED)

By checking the box below, you understand that Pfizer Inc., Pfizer Oncology Together™, Pfizer's affiliates, and its vendors (collectively, "Pfizer") will use the health information you and your healthcare providers provide us to provide you with the Patient Support Activities. You have the right to withdraw these permissions at any time and can do so by contacting Pfizer Oncology Together™ at 1-877-744-5675. You can find more information about how Pfizer Inc. handles your personal information in our Privacy Policy at pfizer.com/privacy.

I understand that I have the right to withdraw my consent by calling 1-877-744-5675, and that if I withdraw my consent it will be effective for any future disclosures but will not affect disclosures already made.

☐ ***I understand and consent to the terms of the Privacy Notice and Consent to Process Health Information.**

4 PATIENT CONSENT TO RECEIVE CALLS AND TEXTS (*REQUIRED)

By providing my mobile number and checking the box below, I or my caregiver agree to receive calls and texts from Pfizer or parties acting on its behalf, to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, refill reminders from Pfizer Oncology Together™, information and other Patient Support Activities (such as copay support or free drug programs) and for other non-marketing purposes (such as enrollment status and shipping updates) at the telephone number(s) I or my caregiver provide.

***Please enter the mobile number you would like to enroll for texting:** _____ – _____ – _____

☐ ***I or my caregiver agree to receive calls and texts from Pfizer or parties acting on its behalf as stated.**

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. I understand that my consent is not required and is not a condition of purchasing any goods or services from Pfizer. Message and data rates may apply. Complete terms can be found at www.pfizeroncologytogether.com/care-champion-text-terms and Pfizer's privacy policy at www.pfizer.com/privacy. Text STOP to opt out.

5 PERSONALIZED PATIENT SUPPORT PROGRAM OPT-IN (Optional)

You can sign up to receive personalized support from a Pfizer Field Reimbursement Manager or Patient Access Navigator (for ELREXFIO patients only) (support specialist) during your treatment journey. After you enroll in Pfizer Oncology Together and opt in for this service, a support specialist will connect with you to provide a wide range of personalized support, including access and financial assistance for eligible patients, and/or referrals patient organizations for resources and support. Working with a support specialist is optional.

☐ By checking this box, I request personalized support and agree to receive telephonic communications from the Pfizer support specialist. 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 Pfizer at any time by contacting Pfizer Oncology Together™ at 1-877-744-5671.

6 PFIZER ONCOLOGY TOGETHER™ CO-PAY SAVINGS PROGRAM FOR INJECTABLES (Optional – for commercially insured patients only)

STOP **Go to 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. 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 PATIENTS

7 PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (*REQUIRED)

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 your 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 and date 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. I consent to Pfizer using my health information for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me. I understand that this form will remain in effect for 4 years from the date of my signature unless state law requires a shorter period or 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. This withdrawal will not affect the use or sharing of my health information that took place before I withdrew my approval. I understand I will receive a copy of this form.

SIGN X _____ _____

Patient Signature* **(Patient or patient representative must be 18 years or older)†** **Date***

SIGN X _____ _____

Patient representative name (please print)‡ **Date**

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

☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions

☐ Other _____

†Patients who are 18 years or older must sign unless incapacitated, otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡NOT required if the patient signs.
§Required if patient representative signs.

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PATIENT INFORMATION

First Name* _____ MI ____ **Last Name*** _____ **Date of Birth** (mm/dd/yyyy)* _____

FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page.

8 HCP/SITE OF CARE INFORMATION (*REQUIRED)

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

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

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

Office Contact Name* _____ **Office Contact Phone*** _____ Ext. _____

Office Fax* _____ Email _____

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

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

Primary Diagnosis ICD-10* _____ Secondary Diagnosis ICD-10 _____

For RUXIENCE only. 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.**

SIGN X _____

For ZIRABEV only. 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.**

SIGN X _____

10 ADMINISTERING PROVIDER INFORMATION (Administering/Overseeing Product Infusion)

☐ Check if same as Section 8 (*REQUIRED, if applicable)

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

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

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

Office Contact Name* _____ **Office Contact Phone*** _____ Ext. _____

Office Fax* _____ Email _____

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PATIENT INFORMATION

First Name* _____ MI ____ **Last Name*** _____ **Date of Birth** (mm/dd/yyyy)* _____

FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page.

11 PRESCRIPTION INFORMATION (*REQUIRED)

Primary Diagnosis ICD-10* _____ Secondary Diagnosis ICD-10 _____

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

☐ **BOSULIF (bosutinib)**	_____ mg, 30-day supply ☐ Tablets ☐ Capsules	☐ **LORBRENA (lorlatinib)**	_____ mg, 30-day supply
☐ **BRAFTOVI (encorafenib)**	☐ 300 mg ☐ 450 mg ☐ Other: _____ ☐ 30-day supply ☐ Other: _____	☐ **MEKTOVI (binimetinib)**	☐ 45 mg ☐ Other: _____ ☐ 30-day supply ☐ Other: _____
☐ **DAURISMO (glasdegib sodium)**	_____ mg, 30-day supply	☐ **TALZENNA (talazoparib)**	_____ mg, 30-day supply, soft gelatin capsules Male HRR+: ☐ Yes ☐ No
☐ **IBRANCE (palbociclib)**	_____ mg, 28-day supply	☐ **VIZIMPRO (dacomitinib)**	_____ mg, 30-day supply
☐ **INLYTA (axitinib)**	_____ mg, 30-day supply	☐ **XALKORI (crizotinib)**	_____ mg, 30-day supply

Directions/Dosing Instructions* _____

INJECTABLES

☐ **BESPONSA (inotuzumab ozogamicin) Single-Dose Vial**	☐ 0.9 mg	
☐ **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	☐ 44 mg/1.1 mL	☐ 76 mg/1.9 mL
☐ **MYLOTARG (gemtuzumab ozogamicin) Single-Dose Vial**	☐ 4.5 mg	
☐ **NIVESTYM (filgrastim-aafi) Single-Dose Vial**	☐ 300 mcg/mL	☐ 480 mcg/1.6 mL
☐ **NIVESTYM (filgrastim-aafi) Prefilled Syringe**	☐ 300 mcg/mL	☐ 480 mcg/0.8 mL
☐ **NYVEPRIA (pegfilgrastim-apgf) Prefilled Syringe**	☐ 6 mg/0.6 mL	
☐ **RUXIENCE (rituximab-pvvr) Single-Dose Vial**	☐ 100 mg/10 mL	☐ 500 mg/50 mL
☐ **TRAZIMERA (trastuzumab-qyyp) Multi-Dose Vial**	☐ 150 mg/vial	☐ 420 mg/vial
☐ **ZIRABEV (bevacizumab-bvzr) Single-Dose Vial**	☐ 100 mg/4 mL	☐ 400 mg/16 mL

Dosing Instructions* _____

12 HEALTHCARE PROVIDER CERTIFICATION for products prescribed in Section 11

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.