Enroll in the BeneFix Trial Prescription Program

To begin, please (1) read the terms and conditions, (2) complete parts 1 to 4 of this enrollment form, and (3) sign the authorization form before returning it to your health care provider. Health care providers, please retain the original signed authorization form with the patient's records and provide them with a copy. The remaining sections must be completed by a health care provider for complimentary products in accordance with the Prescription Drug Marketing Act of 1987. This program is intended for new BeneFIX® Coagulation Factor IX (Recombinant) patients and newly prescribed BeneFix prophylactic patients. See Terms and Conditions below. All products will be sent by the Pfizer Program Administrator.

Fax this completed form, along with the prescription for BeneFIX and the patient authorization form, to 1-888-868-8660. Fax must be sent from a health care provider's office, or mail required documents to the Pfizer Factor Product Trial Prescription Program Administrator, Medvantx, PO Box 5736, Sioux Falls, SD 57117-5736. Please allow 1 to 3 weeks after submission of forms for processing and delivery.

BeneFix Trial Rx Terms and Conditions

OFFER TERMS: By enrolling in the 1-month trial program for Pfizer Factor Product, Patient acknowledges that they currently meet the eligibility criteria and will comply with the terms and conditions described below:

The patient is currently covered by a private (commercial) insurance plan. The patient, or health care provider on the patient's behalf, must provide a completed enrollment form and a valid prescription to the Pfizer Factor Product Trial Prescription Program. **The program is valid for one 1-month trial of up to 20,000 IU of on demand factor or/and 20,000 IU of once weekly factor. The patient, or the health care provider on the patient's behalf, must not submit any claim for reimbursement for product dispensed pursuant to this program to any third-party payer, including Medicaid, Medicare, or any other federal or state health care program. The patient must not apply the value of the free product received through this program toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).** The free trial offer is not valid for prescriptions that are eligible to be reimbursed by private insurance plans or health or pharmacy benefit programs that reimburse you for the entire cost of your prescription drugs. Patients new to therapy or changing from BeneFix on-demand to prophylaxis regime are eligible for the Trial Prescription program. If the patient previously enrolled in the program under on-demand indication they are eligible for a second participation with a new prophylaxis prescription. Program not available where prohibited by law. **This free trial is not health insurance.** This free trial is not intended to address delays or gaps in health insurance coverage for the specified prescription. This program cannot be combined with any other savings, free trial, or similar offers for the specified prescription. **The free trial offer will only be accepted by participating factor providers.** Offer good only in the United States and Puerto Rico. No purchase is necessary. Patients have no obligation to continue to use Pfizer Factor Product. This offer is not transferable. Pfizer reserves the right to rescind, revoke, or amend this free trial program without notice. This free trial program expires 12/31/25. No membership fees. For questions about the Pfizer Factor Product Trial Prescription Program, please call 1-844-989-HEMO (4366) or write to us at Pfizer Factor Product Trial Prescription Program Administrator, Medvantx, PO Box 5736, Sioux Falls, SD 57117-5736.

PARTS 1-4: PATIENT INFORMATION - *To be completed by patient or representative of patient*

1 Name _____ 2 Date of birth _____

3 Address _____
(Street) (Suite/Floor) (City) (State) (ZIP Code)

Telephone number Day _____ Evening _____

4 I am a patient caregiver ☐ _____ Patient caregiver name _____ Patient caregiver phone number

If guardian, please state relationship to patient _____

Signature of patient/parent/guardian _____ Date

PARTS 5-10: PHYSICIAN INFORMATION - *Please ship to the address on line 8*

5 Name _____

6 Professional designation license # (required by law) _____

7 Name of treatment center* _____

8 Address _____
(Street) (Suite/Floor) (City) (State) (ZIP Code)

9 Business telephone ( ) _____ HTC telephone ( ) _____

10 Fax ( ) _____ Email address _____

*If not a treatment center, please fill in physician name and medical center affiliation.

PARTS 11-14: BeneFix TRIAL PRESCRIPTION INFORMATION

11 Please note on the prescription whether patient has any allergies and/or is taking concomitant medications. Maximum quantity based on patient weight, 1-month supply up to 20,000 IU.

12 Will this trial be for once-weekly prophylaxis or on-demand use?
_____ Once-weekly prophylaxis _____ On demand

13 Preferred vial sizes based on patient dosage (subject to availability)
_____ 250 IU vials # _____ 500 IU vials # _____ 1000 IU vials # _____ 2000 IU vials # _____ 3000 IU vials

14 Signature of requesting licensed physician

I agree that I will not resell or bill any third party, including Medicaid or Medicare programs, for any of the complimentary product provided under this trial prescription program. I acknowledge that any patient selected for this program is not currently receiving BeneFix therapy and has not been previously enrolled in the BeneFix Trial Prescription Program.

(Signature of physician) (Date of request)

For questions about the BeneFix Trial Prescription Program, please call 1-844-989-HEMO (4366), Monday through Friday, 9:00 am to 5:00 pm eastern time.
Please see Indication and Important Safety Information on next page and accompanying full Prescribing Information.

Acknowledgments

I understand that I may refuse to sign this authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my health care provider or to seek payment or my eligibility for benefits. However, I understand that I may not be included in the BeneFIX Trial Prescription Program if I refuse to sign this authorization form.

I understand that completing this enrollment form does not guarantee that I will qualify for the BeneFIX Trial Prescription Program.

I understand that medicine received under the BeneFIX Trial Prescription Program shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel the BeneFIX Trial Prescription Program at any time.

HEALTH CARE PROVIDER MUST GIVE PATIENT AND/OR PATIENT'S REPRESENTATIVE A SIGNED COPY OF THIS FORM. Health care provider verified patient representative's authority to act on patient's behalf.

_____(check)

Indication

BeneFix, Coagulation Factor IX (Recombinant), is a human blood coagulation factor indicated in adults and children with hemophilia B (congenital factor IX deficiency or Christmas disease) for the on-demand treatment and control of bleeding episodes, perioperative management of bleeding, and routine prophylaxis to reduce the frequency of bleeding episodes.

Limitation of use:

BeneFix is not indicated for induction of immune tolerance in patients with hemophilia B.

Important Safety Information

- BeneFix is contraindicated in patients who have manifested life-threatening, immediate hypersensitivity reactions, including anaphylaxis, to the product or its components, including hamster protein (CHO).
- Hypersensitivity reactions, including anaphylaxis, have been reported with BeneFix. Closely monitor patients for signs and symptoms of acute anaphylaxis, particularly during the early phases of initial exposure to the product. Immediately discontinue the administration of the product and initiate appropriate treatment if symptoms occur.
- Patients may develop hypersensitivity to hamster protein as BeneFix contains trace amounts.
- BeneFix has been associated with the development of thromboembolic complications, including in patients receiving continuous infusion through a central venous catheter. The safety and efficacy of BeneFix administration by continuous infusion have not been established.
- Neutralizing antibodies (inhibitors) have been reported following the administration of BeneFix. If expected plasma factor IX activity levels are not attained, or if the patient presents with an allergic reaction, or if bleeding is not controlled following an expected dose of BeneFix, perform an assay that measures factor IX inhibitor concentration.
- The most common adverse reactions (>5%) from clinical trials were fever, cough, nausea, injection site reaction, injection site pain, headache, dizziness, and rash.

Please see accompanying full Prescribing Information.

BeneFix®
Coagulation Factor IX (Recombinant)
Room Temperature Storage

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

I authorize (i.e., allow) the use and/or disclosure of my Protected Health Information, described below, which is protected under a federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). In general, Protected Health Information is information, including demographic information, which (1) relates to my past, present, or future physical or mental health or condition, the provision of health care to me, or the past, present, or future payment for the provision of health care to me, and (2) that identifies me or for which there is a reasonable basis to believe can be used to identify me. I understand that this authorization is voluntary.

1. **Person(s) or Class of Person(s) Authorized to Disclose Protected Health Information**: My health care providers, including my treating physicians and medical laboratories, that provide health care to me and conduct medical testing.

2. **Person(s) or Class of Person(s) Authorized to Receive Protected Health Information**: Medvantx, the administrator of the BeneFIX® Coagulation Factor IX (Recombinant) Trial Prescription Program (the "Program"); Pfizer Inc. ("Pfizer"), and other authorized service providers of Pfizer.

3. **Description of Protected Health Information that may be Used and/or Disclosed**: My name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that I am seeking health care services, and data otherwise related to my health condition, diagnosis, and/or treatment.

4. **Purpose(s) for the Use and/or Disclosure of Protected Health Information**: To determine whether I have _____ and other conditions for eligibility under the Program have been met and to provide compensation under the Program.

5. **No Conditioning**. I understand that my treatment, enrollment, eligibility and payment under my health plan are not conditioned upon me signing this form and agreeing to permit the disclosure of my Protected Health Information to Pfizer and its authorized service providers.

6. **Right to Revoke**. I may revoke (i.e., take back) this authorization at any time, except to the extent that my health care providers have taken any action in reliance on my authorization. I understand that if I revoke this authorization, it will not have any effect on any uses or disclosures of my Protected Health Information that occurred prior to receiving my revocation. To revoke, I understand that I must notify my health care provider in writing at the following address _____.

7. **Expiration of Authorization**. This authorization will remain in full force and effect for one year from the date of this authorization, unless I revoke it prior to this time.

8. **Potential for Re-disclosure**. Persons or entities that receive my Protected Health Information under this authorization may not be required by privacy laws (such as HIPAA) to protect the information and they may share it with others without my permission, if permitted by laws that are applicable to them.

9. **Copy of Authorization**. I understand that I am entitled to receive a signed copy of this authorization.

I have read this authorization and/or had its contents read to me. I authorize the use and disclosure of my Protected Health Information as described in 1-9 above.

Signature:_____ Date:_____
Print Name: _____ Relationship*: _____

*If signed by the individual's representative, provide a description of the representative's relationship to the individual and such person's authority to act for the individual (e.g., health care power of attorney).

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL HEALTH INFORMATION

Pfizer Inc. ("Pfizer") collects certain personal health information (described below) about individuals participating in the BeneFIX® Coagulation Factor IX (Recombinant) Trial Prescription Program (the "Program"). Pfizer is seeking this consent because it needs to collect, use and disclose such information, which is considered sensitive information in some states, in connection with operation of the Program.

Health Information Collected and/or Shared. The personal health information Pfizer and its service providers collect includes name, patient identifier, medical records, healthcare provider information, and other data that identifies your health condition, diagnosis, and/or treatment (collectively "Health Information").

Purposes of Collection and Use. Your Health Information will be used for the following purposes:

- To be a part of the BeneFIX Program.

Purposes of Sharing. Your Health Information will be shared for the following purposes:

- To be a part of the BeneFIX Program.

Duration. By signing the consent to use and/or the consent to disclose, I agree that these entities may use and/or disclose my Health Information to administer the Program or as permitted or required by applicable privacy laws. I permit such use and/or disclosures for one year after the dates I sign each consent respectively, unless and until I revoke (i.e., take back) it in writing prior to that time.

Revocation. I may revoke my consent at any time, except to the extent that Pfizer has taken any action in reliance on my consents. I understand that if I revoke my consent, it will not have any effect on any collection, uses, or disclosures of my Health Information that occurred prior to receiving my revocation. To revoke, I understand that I must notify Pfizer in writing at https://www.pfizer.com/ contact using the email template.

I understand that both my consent to collect and use and my consent to disclose my Health Information are voluntary and may be revoked in writing at any time. I further understand that not permitting the processing of my Health Information may result in my health plan or insurer not being able to participate in the Program.

I have read this consent and/or had its contents read to me. I fully understand the terms and conditions described above.

Consent to Collect Health Information:

☐ By checking this box as of the date below, I am signing this consent on my own free will and I agree to the collection and use of my Health Information as described above. I understand that a signed copy of this consent is available to me upon request.

Consent to Disclose Health Information:

☐ By checking this box as of the date below, I am signing this consent on my own free will and I agree to the disclosure of my Health Information as described above. I understand that a signed copy of this consent is available to me upon request.

BeneFix
Coagulation Factor IX (Recombinant)
Room Temperature Storage