

# FULL TERMS AND CONDITIONS

## VELSIPITY (etrasimod) Copay Savings Program Terms and Conditions

By participating in the VELSIPITY Copay Savings Program and using the VELSIPITY Copay Savings Card (the “Program”), you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:

- Patients are not eligible to use this Program if they are 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 assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as “La Reforma de Salud”).
- Patient must have private insurance.
- Offer is not valid for cash paying patients.
- Patients who move from private insurance to the above-mentioned state or federal healthcare insurance programs will no longer be eligible.
- Offer is only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY (etrasimod).
- The value of the prescription offer is limited to the amount of your copay. Patients may pay as little as \$0 in out-of-pocket costs per prescription, subject to a maximum benefit of \$4,000 to \$16,000 during a calendar year.
- **The value of the offer for reimbursement of qualified out-of-pocket expenses is a one-time reimbursement amount of up to \$2,500**, which include baseline assessments/prescreening tests for the initial blood tests, ECG screening, eye exam, and baseline skin examination where the full cost is not covered by patient’s insurance. **This offer only applies to the above-mentioned qualified expenses and is not eligible for patients residing in Minnesota or Rhode Island.**
- To receive reimbursement for qualified out-of-pocket expenses, an Explanation of Benefits (EOB) form must be submitted, along with copies of receipts for any payments made. After the \$2,500 maximum is reached, you will be responsible for paying the remaining monthly out-of-pocket costs.
- Patients must be 18 years of age or older to redeem the Card.
- This Program is not valid when the entire cost of your prescription drug and/or qualified out-of-pocket expense are eligible to be reimbursed by your private insurance plan or other private health or pharmacy benefit programs.
- You must deduct the value of this Card from any reimbursement request submitted to your private insurance plan, either directly by you or on your behalf.
- You are responsible for reporting use of the Card to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription and/or qualified out-of-pocket expenses filled using this Program, as may be required.
- You should not use this Program if your insurer or health plan prohibits use of manufacturer Cards.
- The program is not valid where prohibited by law.

- The benefit under the Program is offered to, and intended for the sole benefit of, eligible patients and may not be transferred or utilized for the benefit of third parties, including, without limitation, third party payers, pharmacy benefit managers, or agents of either.
- This program cannot be combined with any other savings, free trial, or similar offer for the specified prescription (including any program offered by a third-party payer or pharmacy benefit manager, or agent of either, that adjusts patient cost-sharing obligations, through arrangements that may be referred to as “accumulator” or “maximizer” programs).
- Third party payers, pharmacy benefit managers, or agents of either, are prohibited from assisting patients with enrolling in the Program.
- **The prescription offer of the Copay Savings Program will be accepted only at participating pharmacies.**
- **If your pharmacy does not participate, you may be able to submit a request for a rebate of the cost for the prescription in connection with this offer. The rebate form can be found at [www.VELSIPITY.com](http://www.VELSIPITY.com).**
- **The Copay Savings Program is not health insurance.**
- Offer good only in the U.S. and Puerto Rico. The Card is limited to 1 per person during this offering period and is not transferable.
- The Card may not be redeemed more than once per 30 days per patient.
- No other purchase is necessary.
- Data related to your redemption of the Card may be collected, analyzed, and shared with Pfizer, for market research and other purposes related to assessing Pfizer’s programs. Data shared with Pfizer will be aggregated and de-identified; it will be combined with data related to other Program redemptions and will not identify you.
- Pfizer reserves the right to rescind, revoke, or amend the Program without notice.
- Program expires 12/31/2026.
- If you have questions or are in need of additional support, call 800-350-3080, visit [www.VELSIPITY.com](http://www.VELSIPITY.com) or mail VelsipityForMe at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067.

#### **VELSIPITY AT-HOME BASELINE ASSESSMENT/PRESCREENING TESTS AND IN OFFICE SCHEDULING PROGRAM TERMS AND CONDITIONS**

**By agreeing to participate in the VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program or the In Office Scheduling Program, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:**

- Patients are not eligible for the VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program and/or In Office Scheduling Program if they are enrolled in Medicare, Medicaid, or other federal or state healthcare programs, or if they reside in Michigan, Minnesota, or Rhode Island.
- **The VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program and In Office Scheduling Program are valid only for patients with commercial (private) insurance.**

- The VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program include initial blood test, ECG screening, and eye exam.
- The In Office Scheduling Program includes scheduling for skin testing and an eye exam only based upon certain identified demographic criteria.
- **The VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program and In Office Scheduling Program are not health insurance.**
- Patients must be enrolled in the VelsipityForMe program to participate in the VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program and/or the In Office Scheduling Program.
- Offers are only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY (etrasimod).
- Offer is only good in the U.S. and Puerto Rico.
- No other purchase is necessary.
- The programs are not valid where prohibited by law.
- Patient must be 18 years of age or older.
- If requesting either an ECG and or initial blood test through the At-Home Baseline Assessment/Prescreening Tests Program, other support services offered through VelsipityForMe cannot begin until a signed Baseline Assessment Confirmation form is received by VelsipityForMe.
- Pfizer reserves the right to rescind, revoke, or amend the programs without notice.
- If you have questions or are in need of additional support, call 800-350-3080, visit [www.VELSIPITY.com](http://www.VELSIPITY.com), or mail to VelsipityForMe at 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067.

## **VELSIPITY ECG INTERPRETATION TERMS AND CONDITIONS**

**By agreeing to participate in the VELSIPITY ECG Interpretation Program, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:**

- Patients are not eligible for the VELSIPITY ECG Interpretation Program if they are enrolled in Medicare, Medicaid, or other federal or state healthcare programs, or if they reside in Michigan, Minnesota, or Rhode Island.
- The VELSIPITY ECG Interpretation Program is valid only for patients with commercial (private) insurance.
- Offer is only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY (etrasimod).
- The VELSIPITY ECG Interpretation Program is only available to patients if an ECG has been previously conducted within 6 months of the request for service.
- **The VELSIPITY ECG Interpretation Program is not health insurance.**

- Patients must be enrolled in the VelsipityForMe program to participate in the VELSIPITY ECG Interpretation Program.
- Offer only good in the U.S. and Puerto Rico.
- No other purchase is necessary.
- The program is not valid where prohibited by law.
- Patient must be 18 years of age or older.
- Other patient support services offered through VelsipityForMe cannot begin until a signed Baseline Assessment Confirmation form is received by VelsipityForMe by the prescribing health care provider.
- Pfizer reserves the right to rescind, revoke, or amend the program without notice.
- If you have questions or are in need of additional support, call 800-350-3080, visit [www.VELSIPITY.com](http://www.VELSIPITY.com) or mail VelsipityForMe at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067.

#### **COPAY SAVINGS CARD REBATE TERMS AND CONDITIONS**

**By sending this rebate you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:**

- Patients are not eligible to participate in this program if they are 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 assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as “La Reforma de Salud”).
- Offer is only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY (etrasimod).
- This rebate is not valid when the entire cost of your prescription drug is eligible to be reimbursed by your private insurance plan or other private health or pharmacy benefit programs.
- The value of the prescription offer is limited to the amount of your copay. Patients may receive up to a maximum benefit of \$4,000 to \$16,000 per calendar year, which is defined by the date of enrollment through December 31st of the enrollment year.
- Patient must submit a completed rebate request form and the original, dated store-identified receipt accompanying your prescription as proof of purchase to the address provided on this form. Receipt will not be returned. See instructions on rebate request form.
- Rebate will be mailed to patients approximately 6 to 8 weeks after receipt of required documentation or earlier, as required by law.
- You must deduct the value received under this rebate from any reimbursement request submitted to your private insurance plan, either directly by you or on your behalf. Patient is responsible for reporting receipt of rebate to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription for which the patient receives a rebate, as may be required. You should not use this

program if your private insurer or health plan prohibits use of manufacturer coupons, copay cards, debit cards, or similar savings programs.

- This rebate is not valid where prohibited by law.
- This rebate cannot be combined with any other savings, free trial, or similar offer for the specified prescription.
- **This rebate is not health insurance.**
- Offer good only in the U.S. and Puerto Rico.
- No other purchase is necessary.
- Data related to your redemption of the rebate may be collected, analyzed, and shared with Pfizer, for market research and other purposes related to assessing Pfizer's programs.
- Data shared with Pfizer will be aggregated and de-identified; it will be combined with data related to other rebate redemptions and will not identify you.
- Pfizer reserves the right to rescind, revoke, or amend the program without notice.
- Rebate and Program expire 12/31/2026.
- If you have questions or are in need of additional support, call 800-350-3080 or visit [www.VELSIPITY.com](http://www.VELSIPITY.com), or mail VelsipityForMe at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067.

#### **VELSIPITY® (etrasimod) Interim Care Program: TERMS AND CONDITIONS**

Interim Care is not health insurance and is available for eligible, commercially insured patients only. Offer is only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY® (etrasimod). The Interim Care Program is applicable to all VELSIPITY® formulations. No claim for reimbursement for product dispensed pursuant to this offer may be submitted to any third-party payer. Not available to patients covered under Medicaid, Medicare or other federal or state healthcare programs, including any state prescription drug assistance programs and the Government Health Insurance Plan or for residents of Massachusetts or Michigan. For residents of Minnesota or Rhode Island, available for up to six months. For all other eligible patients, this program is available for a period of up to two years (lifetime maximum) or until they receive insurance coverage approval, whichever occurs earlier. Available in 30-day supply. Refills are subject to limitations. Continued eligibility for the program requires, 1. submission of first appeal within 60 days of enrollment (or within the required payer timeline, if sooner) in the Interim Care Program and submission of the second appeal, if allowed by the payer, within 60 days of the date of the first appeal denial (or within the required payer timeline, if sooner), 2. satisfying all payer appeal requirements and 3. patients schedule their initial prescription dispense within 60 days of enrollment. If at any time during the patient's Interim Care Program enrollment there is a payer coverage change relating to the applicable product, Pfizer may conduct a new benefits investigation, and, if allowed by the payer, submission of a new Prior Authorization request and an appeal, if denied, must be submitted within 60 days (or within the required payer timeline, if sooner) of either, 1. the date of completion of the benefits investigation, provided by the VelsipityForMe Program to the patient's authorized healthcare provider, or 2. the date a new submission is allowed by the payer, for continued eligibility in the program, whichever is later. Submission of the second appeal, if allowed by the payer, is required within 60 days of the date of the first appeal denial (or within

the required payer timeline, if sooner). If there is no payer coverage change, at 12 months of Interim Care Program enrollment, an updated prescription and benefits investigation is required to confirm continued eligibility. Interim Care offer does not require, nor will be made contingent on, purchase requirements of any kind. Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification. Interim Care can only be dispensed by the exclusive pharmacy and only after a benefits investigation has been completed and a delay occurs in the Prior Authorization process, or an appeal is required. All payer appeal timelines must be met for continued assistance. Offer good only in the U.S. and Puerto Rico. Prescription must be provided by a healthcare provider licensed in the U.S. or Puerto Rico. Additional eligibility criteria may apply. Contact VelsipityForMe at 1-800-350-3080 for details.

## VOUCHER PROGRAM TERMS AND CONDITIONS

- You will receive a one-time 30-day supply of VELSIPITY.
- Only new patients may use this voucher and each patient is limited to one voucher. By redeeming this voucher, you certify that you are not currently using VELSIPITY.
- This voucher may not be transferred, sold, purchased, traded, or counterfeited.
- An original voucher and a valid prescription must be presented to the pharmacy.
- **The voucher will be accepted only at participating pharmacies.**
- **You must not submit any claim for reimbursement for product dispensed pursuant to this voucher to any third party payor, including Medicare, Medicaid, or any other federal or state health care program. You cannot apply the value of the free product received through this voucher toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).**
- You must be 18 years of age or older to redeem this voucher.
- This voucher is not valid for Massachusetts residents whose prescriptions are covered in whole or in part by third party insurance.
- This voucher is not valid where prohibited by law.
- This voucher cannot be combined with any other external savings, free trial or similar offer for the specified prescription. This voucher should not be combined with samples for the specified prescription.
- **This free trial voucher is not health insurance.**
- **This free trial voucher may not be used to address delays or gaps in health insurance coverage for the specified prescription.**
- Offer good only in the U.S. and Puerto Rico.
- No purchase is necessary.
- Patients have no obligation to continue to use VELSIPITY.
- Pfizer reserves the right to rescind, revoke or amend this offer without notice.
- This voucher expires 12/31/2026.