Pfizer Oncology together™

PATIENT REIMBURSEMENT SUPPORT SERVICES ENROLLMENT FORM

FAX completed forms to **1-877-736-6506** | MAIL to **Pfizer Oncology Together, 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067**

QUESTIONS? Call 1-877-744-5675, M–F, 8 AM–8 PM ET

JUST LOOKING FOR INJECTABLES CO-PAY ASSISTANCE? Visit pfizercopay.com
JUST LOOKING FOR ORALS CO-PAY ASSISTANCE? Visit pfizeroncologytogether.com

PATIENTS COMPLETE THIS FORM ONLINE at pfizeroncologytogether.com (paper version is not needed if the form is completed online. **If completing this form by hand, please print clearly. Do not use cursive.**)

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.

Benefits Investigation – When a payer coverage issue requires research ONLY

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

For Co-pay assistance for the below products, go to pfizercopay.com

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

ORALS

☐ **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)*
☐ TUKYSA® (tucatinib)*
☐ VIZIMPRO® (dacomitinib)*
☐ XALKORI® (crizotinib)*

***For Co-pay assistance go to pfizeroncologytogether.com**

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 Pfizer Oncology Together™.

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

1 PATIENT INFORMATION (*REQUIRED)

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

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

Address* _____

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

Primary Phone* _____ ☐H ☐M ☐W

Best Time to Contact: ☐Morning ☐Afternoon ☐Evening

Preferred Language if not English: _____

Preferred Method of Communication: _____ Email _____

Caregiver First Name _____ Caregiver Last Name _____

Caregiver Phone _____ Caregiver Email _____

2 INSURANCE INFORMATION

Insurance Type (Check all that apply)*: ☐**Commercial** ☐**Medicare Part D** ☐**Medicare Advantage** ☐**Medicare A/B only** ☐**Medicaid** ☐**VA Benefits** ☐**Other** _____ ☐**None†**

(*REQUIRED only if front and back copies of insurance card[s] are NOT submitted with the completed form)

	Primary Medical Insurance*	Primary Prescription Insurance*	Secondary Prescription Insurance
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.

FOR PATIENTS

3 CONSENT TO COLLECT AND USE PERSONAL DATA (*REQUIRED)

Pfizer Inc. ("Pfizer") collects certain Personal Data (described below) about individuals so that it may provide patient support services to eligible patients through the Pfizer Oncology Together Program (the "Program"). Pfizer is seeking this consent because it needs to collect and use such data, which is considered sensitive data in some jurisdictions, in connection with operation of the Program.

Personal Data Collected and/or Used. The Personal Data Pfizer and its service providers may collect and use includes name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that you are seeking health care services, and data otherwise related to your health condition, diagnosis, and/or treatment (collectively "Personal Data").

Purposes of Collection and Use. Your Personal Data will be used for the following purposes: Your Personal Data will be used by Pfizer who will provide patient support services to eligible patients including, where applicable, determining eligibility for co-pay support and free drug programs,

Duration. By signing this consent to collect and use, I agree that these entities may use the Personal Data to provide applicable patient support services or as permitted or required by applicable privacy laws. I permit such use for two years after the date I sign the consent, 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 consent. I understand that if I revoke my consent, it will not have any effect on any collection, uses, or disclosures of my Personal Data that occurred prior to receiving my revocation. To revoke, I understand that I must notify Pfizer Oncology Together by emailing privacy@sonexushealth.com or by calling 1-877-744-5675, 8 AM–8 PM ET, M–F. I understand that my consent to collect and use my Personal Data is voluntary and may be revoked in writing at any time.

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 Personal Data:

By signing and dating below, I consent on my own free will and I agree to the collection and use of my Personal Data as described above. I understand that a signed copy of this consent to available to me upon request.

SIGN X _____ _____ _____

Patient Signature* **(Patient or patient representative must be 18 years or older)†** | **Patient representative name (please print)‡** | **Date** (mm/dd/yyyy)*

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 _____

4 CONSENT TO RECEIVE TEXT MESSAGES (*REQUIRED)

By providing your phone number _____, you consent to receive communications from Pfizer with information regarding the Pfizer Oncology Together Program.You understand that providing this consent is not required or a condition of purchasing any products or services. Message frequency varies. 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 of text messages.

5 PERSONALIZED PATIENT SUPPORT PROGRAM OPT-IN (Optional)

You can sign up to receive personalized support from a Pfizer Field Reimbursement Director 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 to 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 1-877-744-5675.

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

FOR PATIENTS

6 HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (*REQUIRED)

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:** Pfizer Inc. ("Pfizer"), Pfizer Oncology Together (the "Program"), 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 conditions for eligibility under the Program have been met; and to provide me with various support to help me access a Pfizer medicine, which may include the following:

   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
   - Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services
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 Pfizer Oncology Together™ by emailing privacy@sonexushealth.com or by calling 1-877-744-5675, 8 AM–8 PM ET, M–F.
7. **Expiration of Authorization.** This authorization will remain in full force and effect for two years 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.

SIGN X _____ _____ _____

Patient Signature* **(Patient or patient representative must be 18 years or older)†** **Patient representative name (please print)‡** **Date** (mm/dd/yyyy)*

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 above 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 – Please complete the form where applicable and return via fax or mail if information is not submitted online at pfizeroncologytogether-portal.com. If completing this form by hand, please print clearly. Do not use cursive. All pages must be returned to Pfizer Oncology Together™.

7 PRESCRIPTION INFORMATION (*REQUIRED)

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

INJECTABLES

☐ **BESPONSA (inotuzumab ozogamicin) Single-Dose Vial**	☐ 0.9 mg	
☐ **ELREXFIO (elranatamab-bcmm) Single-Dose Vial (40 mg/mL)***	☐ 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

*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.

Directions/Dosing Instructions* _____

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 _____

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

Dosing Instructions* _____

8 HEALTHCARE PROVIDER CERTIFICATION for products prescribed in Section 7

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.

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PATIENT INFORMATION

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9 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

10 ADMINISTERING PROVIDER INFORMATION (Administering/Overseeing Product Infusion)

☐Check if same as Section 9 (*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 _____