Pfizer GeneTogether™ Co-Pay Claim Form

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Eligibility

Patients may be eligible for this offer if they:

- Have commercial insurance that covers BEQVEZ™ (fidanacogene elaparvovec-dzkt)
- Are not enrolled in a state- or federally funded health insurance program

Claims Process

NOTE: Patients must be enrolled in the Pfizer GeneTogether Co-Pay Program.

Please submit the following:

1. A completed Pfizer GeneTogether Co-Pay Claim Form, CMS-1500, or UB-04 within 180 days of the date of service shown on the patient's Explanation of Benefits (EOB)
2. A copy of the EOB

Contact Us

Please fax the completed Pfizer GeneTogether Co-Pay Claim Form, CMS-1500, or UB-04, along with the EOB, to 1-877-847-3291, or visit www.PfizerCopay.com to select the appropriate co-pay portal and submit the form.

For BEQVEZ, Pfizer GeneTogether Case Managers are available Monday through Friday, 8 AM to 8 PM ET, at 1-888-733-2030. If there are any changes to the patient's provider, administering provider, insurance, or contact information, call Pfizer GeneTogether prior to the submission of the co-pay claim form.

Terms and Conditions: By using this co-pay card, 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 card 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 with coverage for Beqvez. Offer is not valid for cash paying patients. The value of this co-pay card is limited to $25,000 per use or the amount of your co-pay, whichever is less. This co-pay card 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. You must deduct the value of this co-pay 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 co-pay card to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the co-pay card, as may be required. You should not use the co-pay card if your insurer or health plan prohibits use of manufacturer co-pay cards. You must be 18 years of age or older to redeem the co-pay card. This co-pay card is not valid for Massachusetts residents whose prescriptions are covered in whole or in part by third party insurance. This co-pay card is not valid where prohibited by law. The benefit under the co-pay card program is offered to, and intended for the sole benefit of, eligible patients and may not be transferred to or utilized for the benefit of third parties, including, without limitation, third party payers, pharmacy benefit managers, or the agents of either. Co-pay card cannot be combined with any other external savings, free trial or similar offer for the specified prescription (including any program offered by a third-party payer or pharmacy benefit manager, or an 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 the agents of either, are prohibited from assisting patients with enrolling in the co-pay card program. **Co-pay card will be accepted only at participating pharmacies. This co-pay card is not health insurance.** Offer good only in the U.S. and Puerto Rico. Co-pay card is limited to 1 per person during this offering period and is not transferable. A co-pay card may not be redeemed more than once per patient per lifetime. No other purchase is necessary. Data related to your redemption of the co-pay 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 co-pay card redemptions and will not identify you. Pfizer reserves the right to rescind, revoke or amend this offer without notice. Offer expires 12/31/2024.

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All fields marked with an asterisk (*) are required.

*Person completing form: ☐ Patient ☐ Healthcare Providers ☐ Specialty Pharmacy

ADMINISTERING PROVIDER *(Enter the name of the administering provider or infusion center)*

PRACTICE NAME

*PROVIDER FIRST NAME

*PROVIDER LAST NAME

PATIENT

*PATIENT FIRST NAME

*PATIENT LAST NAME

PATIENT M.I.

*GENDER ☐ Male ☐ Female

*ZIP CODE

*DATE OF BIRTH

*DATE OF SERVICE

*PATIENT OUT-OF-POCKET AMOUNT FOR PRODUCT

UPDATED INSURANCE DETAIL *(If the insurance has changed since last submission)*

PRIMARY INSURANCE NAME

PRIMARY INSURANCE GROUP #

PRIMARY INSURANCE ID

CO-PAY CLAIM PAYMENT INFORMATION *(Contact and address where payment should be sent)*

*CHECK PAYABLE TO

*STREET ADDRESS

*CITY

*STATE

*ZIP CODE

EMAIL

FAX NUMBER

*NPI NUMBER

*TAX ID NUMBER

