Pfizer Oncology together™

PATIENT REIMBURSEMENT SUPPORT SERVICES ENROLLMENT FORM

MAIL to Pfizer Oncology Together
2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067

FAX completed forms to **1-877-736-6506**

UPLOAD completed forms at **pfizeroncologytogether-portal.com/upload**

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. Once complete, return via fax or online at pfizeroncologytogether-portal.com/upload. You may also submit via mail at the address above, which may delay assistance.**)

INJECTABLES

Reimbursement Support – To determine the patient's health insurance coverage, payer requirements, and out-of-pocket costs

- ☐ ADCETRIS® (brentuximab vedotin)
- ☐ ELREXFIO™ (elranatamab-bcmm)
- ☐ TIVDAK™ (tistotumab vedotin-tftv)

See Section 4 for opt-in information regarding individual access, reimbursement, or other support available through a Patient Access Navigator for ELREXFIO or Field Reimbursement Director for all other products.

Benefits Investigation – When a payer coverage issue requires research ONLY

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

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)
- ☐ XALKORI® (crizotinib)

Getting started with Pfizer Oncology Together™

Read these helpful tips to complete the Pfizer Oncology Together™ enrollment form.

IMPORTANT NOTE: The patient must sign and date all applicable form sections unless they are incapacitated and unable to sign or under 18 years of age. If this form is filled out by hand, all responses must be printed clearly. Do not use cursive handwriting.

TIPS FOR PATIENTS

BEFORE YOU SUBMIT, MAKE SURE TO COMPLETE THE REQUIRED STEPS:

- For Reimbursement Support Services, complete **Section 1** and **Section 2**
- Read, sign, and date **Section 3** and **Section 5**
- If submitting a paper form—other than your signature, please print and do NOT use cursive

Have you completed the required steps above?

TIPS FOR HCP

To enroll your patient in Pfizer Oncology Together™ and submit their prescription, you have 3 options:

1. Go to pfizeroncologytogether-portal.com
2. Go to pfizeroncologytogether.com for online enrollment **OR**
3. Fax or mail a paper enrollment form and **MAKE SURE TO COMPLETE THE REQUIRED STEPS:**
   - Complete **Pages 4 and 5**
   - Send an eRx to: Sonexus Health Pharmacy Services (SHPS) NPI number - 1447680210; NCPDP 5910206

Have you completed the required steps above?

FOR PATIENTS – Complete the following sections; then read, sign, and date (where applicable) the required authorization and consents. MISSING REQUIRED FIELDS (*) WILL DELAY THE ABILITY OF THE PROGRAM TO INITIATE SUPPORT AND/OR FILL YOUR PRESCRIPTION.

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

HCP Phone* _____ **HCP Fax*** _____

1 PATIENT INFORMATION (*REQUIRED)

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

Date of Birth (mm/dd/yyyy)* _____ **Sex*** (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 _____

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FOR PATIENTS

2 INSURANCE INFORMATION

Insurance Type (Check all that apply)*: ☐ Commercial ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicare A/B only ☐ Medicaid ☐ VA Benefits ☐ Other _____ ☐ Uninsured†

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

	Primary Medical Insurance*	Primary Prescription Insurance*
Policyholder Name*		
Insurance Name*		
Insurance Phone*		
Policy ID #*		
Group #*		
BIN #*		
PCN #*		

†If Uninsured 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.

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 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.

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FOR PATIENTS

5 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.
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PATIENT INFORMATION **First Name*** _____ MI ____ **Last Name*** _____ **Date of Birth** (mm/dd/yyyy)* _____

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

FOR HEALTHCARE PROFESSIONALS – Please complete the form where applicable and return via fax or online at pfizeroncologytogether-portal.com/upload. You may also submit via mail at the address above, which may delay assistance. If completing this form by hand, please print clearly. Do not use cursive. All pages must be returned to Pfizer Oncology Together™. MISSING REQUIRED FIELDS (*) WILL DELAY THE ABILITY OF THE PROGRAM TO INITIATE SUPPORT AND/OR FILL THE PRESCRIPTION.

6 HEALTHCARE PROVIDER CERTIFICATION for products prescribed in Section 7

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

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 below therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge.

7 PRESCRIPTION INFORMATION (*REQUIRED)

INJECTABLES

☐ **ADCETRIS (brentuximab vedotin)**	☐ 50 mg
☐ **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
☐ **TIVDAK (tistotumab vedotin-tftv)**	☐ 40 mg

*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* _____

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: _____
☐ **XALKORI (crizotinib)**	_____ mg, 30-day supply

Dosing Instructions* _____

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

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

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8 HCP/SITE OF CARE INFORMATION (*REQUIRED)

HCP First Name* _____ HCP Last Name* _____

Practice Name* _____ NPI #* _____

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

Office Contact Full Name _____ Title _____

Office Contact Phone* _____ Office Fax* _____

Office Contact Email _____ Preferred Communication Method: ☐ Phone ☐ Fax

9 ADMINISTERING PROVIDER INFORMATION (Administering/Overseeing Product Infusion)

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

HCP First Name* _____ HCP Last Name* _____

Practice Name* _____ NPI #* _____

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

Office Contact Full Name _____ Title _____

Office Contact Phone* _____ Office Fax* _____

Office Contact Email _____ Preferred Communication Method: ☐ Phone ☐ Fax