Pfizer enCompass®

STOP **JUST LOOKING FOR CO-PAY ASSISTANCE?** Visit PfizerCoPay.com

Pfizer enCompass® Enrollment Form for INFLECTRA® (infliximab-dyyb) for Injection and RUXIENCE® (rituximab-pvvr)

Please complete and fax this form to 1-844-482-4482 or mail to Pfizer Inc. ("Pfizer") at Pfizer enCompass, 2730 S. Edmonds Lane Suite 300, Lewisville, TX 75067
For assistance call: 1-844-722-6672, Monday–Friday, 8 AM–8 PM ET

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

Please check product: ☐ INFLECTRA 100 mg vial ☐ RUXIENCE* 100 mg/10 mL SDV ☐ RUXIENCE* 500 mg/50 mL SDV

Please check the appropriate box(es) and complete the enrollment form as described below

- ☐ For benefit verification support patients complete sections 1-3 and page 3; healthcare providers complete sections 1-3
- ☐ For prior authorization assistance patients complete sections 1-3 and pages 3; healthcare providers complete sections 1-3
- ☐ For Pfizer enCompass Co-Pay Assistance Program patients also must complete section 4. Enrollment into the co-pay assistance program may also be completed at PfizerCopay.com.

For Patient to Complete

1. PATIENT INFORMATION *INDICATES REQUIRED FIELDS

*NAME (FIRST, MI, LAST) *SEX ☐ MALE ☐ FEMALE ☐ NOT DISCLOSED

*STREET ADDRESS *CITY *STATE *ZIP

*DATE OF BIRTH (MM/DD/YY) EMAIL *PHONE

LANGUAGE PREFERENCE ☐ PATIENT CAREGIVER CAREGIVER NAME CAREGIVER PHONE

2. INSURANCE INFORMATION *INDICATES REQUIRED FIELDS

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD(S)

☐ CHECK HERE IF PATIENT DOES NOT HAVE INSURANCE ☐ CHECK HERE IF PATIENT HAS SECONDARY INSURANCE

PRIMARY INSURANCE INSURANCE TYPE: ☐ COMMERCIAL ☐ MEDICARE A/B ☐ MEDICARE PART D ☐ OTHER

*INSURANCE NAME *INSURANCE PHONE

*MEMBER ID NUMBER *GROUP ID NUMBER

*POLICYHOLDER NAME *POLICYHOLDER RELATIONSHIP TO PATIENT *POLICYHOLDER DATE OF BIRTH (MM/DD/YY)

SECONDARY INSURANCE

*INSURANCE NAME *INSURANCE PHONE

*MEMBER ID NUMBER *GROUP ID NUMBER

*POLICYHOLDER NAME *POLICYHOLDER RELATIONSHIP TO PATIENT *POLICYHOLDER DATE OF BIRTH (MM/DD/YY)

PRESCRIPTION INSURANCE

PRESCRIPTION INSURANCE NAME PRESCRIPTION INSURANCE PHONE

PRESCRIPTION POLICY ID NUMBER PRESCRIPTION GROUP ID NUMBER

PRESCRIPTION BIN PRESCRIPTION PCN

PREFERRED SPECIALTY PHARMACY

*PREFERRED SPECIALTY PHARMACY NAME ☐ SELF-DISPENSING PHARMACY

The patient identified above prefers use of the Specialty Pharmacy indicated above. I authorize Pfizer and its affiliates, agents, representatives, and service providers to fax this prescription to the Specialty Pharmacy designated above, provided it is approved by this patient's plan. If the Specialty Pharmacy designated is not a plan-approved Specialty Pharmacy, then fax to a Specialty Pharmacy approved by this patient's plan. If there is no preferred Specialty Pharmacy indicated, then fax to any Specialty Pharmacy approved by this patient's plan.

See next page to continue completing the Patient section of the Enrollment Form.

*Pfizer enCompass supports patients prescribed INFLECTRA and RUXIENCE for Rheumatoid Arthritis (RA). Patients prescribed RUXIENCE for FDA-approved oncology indications may be supported by Pfizer Oncology Together. For more information, visit www.pfizeroncologytogether.com.

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* PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)

3. PRIVACY NOTICE AND CONSENT TO PROCESS HEALTH INFORMATION AND PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing below/other affirmative act, you understand that Pfizer, Inc., the Pfizer Patient Assistance Foundation, Pfizer's affiliates, and its vendors (collectively, "Pfizer") will use the health information you and your healthcare providers provide us to provide you with the Patient Support Activities. You have the right to withdraw these permissions at any time and can do so by calling Pfizer enCompass at 844-722-6672. You can find more information about how Pfizer Inc. handles your personal information in our Privacy Policy at pfizer.com/privacy.

By using the boxes below, you can also agree to permit Pfizer to use the information you provide for additional specified purposes:

I understand that I have the right to withdraw my consent by calling Pfizer enCompass at 844-722-6672, and that if I withdraw my consent(s) it will be effective for any future disclosures but will not affect disclosures already made.

☐ **I understand and consent to the terms of the Privacy Notice and Consent to Process Health Information**

By signing this form, I agree to receive calls and texts from Pfizer or parties acting on its behalf, including calls and texts that use an autodialer or include artificial/prerecorded voice, to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, refill reminders from Pfizer enCompass, information and other Patient Support Activities (such as copay support or free drug programs) and for other non-marketing purposes (such as enrollment status and shipping updates) at the telephone number(s) I provide. I understand that my consent is not required and is not a condition of purchasing any goods or services from Pfizer. Message and data rates may apply. Text HELP to 82000 for information and STOP to opt out.

If I have a caregiver, he or she has also agreed to receive calls and texts, including calls and texts that use an autodialer or include artificial/prerecorded voice and hereby gives his or her permission for Pfizer, Pfizer enCompass, and/or parties acting on their behalf to contact him or her for such purposes at the phone number(s) provided. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer enCompass at 1-844-722-6672, Monday–Friday, 8 AM–8 PM ET.

***PRINT NAME OF PATIENT**

***PATIENT SIGNATURE** (PATIENT OR PATIENT REPRESENTATIVE)

PATIENT REPRESENTATIVE NAME (PLEASE PRINT REQUIRED IF SIGNING ON BEHALF OF THE PATIENT)

***DATE**

IF SIGNED BY PATIENT REPRESENTATIVE, PLEASE INDICATE BELOW THE AUTHORITY TO ACT ON BEHALF OF PATIENT:

☐ COURT APPOINTED ☐ GUARDIAN ☐ POWER OF ATTORNEY, INCLUDING AUTHORITY TO MAKE HEALTHCARE DECISIONS

☐ OTHER

See next page to continue completing the Patient section of the Enrollment Form.

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* PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)

4. PATIENT CONSENT AND ATTESTATION IF REQUESTING CO-PAY ASSISTANCE (REQUIRED IF APPLYING FOR CO-PAY ASSISTANCE)

Co-Pay Program Consent and Attestation: The checkboxes below must be completed if you are requesting enrollment in the Pfizer enCompass Co-Pay Assistance Program.

☐ Yes ☐ No I attest that I am not enrolled in a state- or federally-funded insurance program, including but not limited to, Medicare, Medicaid, TRICARE, Veterans Affairs healthcare, a state prescription drug program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud"). I attest that I am not over 65 years of age and retired. I attest that I do not receive Social Security Disability (SSDI) or any other Social Security Administration (SSA) benefit. I further attest that I am not active duty military nor are any of my immediate family members.

☐ Yes ☐ No By checking this box, I confirm that I am eligible to participate in this program and agree to the Terms and Conditions specified here or available at www.PfizerCoPay.com. Please agree to the Terms and Conditions before proceeding.

***PRINT NAME OF PATIENT**

***PATIENT SIGNATURE** (PATIENT OR PATIENT REPRESENTATIVE)

PATIENT REPRESENTATIVE NAME (PLEASE PRINT. REQUIRED IF SIGNING ON BEHALF OF THE PATIENT)

***DATE**

IF SIGNED BY PATIENT REPRESENTATIVE, PLEASE INDICATE BELOW THE AUTHORITY TO ACT ON BEHALF OF PATIENT:

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☐ OTHER

If you have questions relating to your eligibility for the Pfizer enCompass Co-Pay Assistance Program for INFLECTRA and RUXIENCE, you can contact Pfizer enCompass and provide your commercial insurance information to verify eligibility. Terms and Conditions apply. For full Terms and Conditions for INFLECTRA and RUXIENCE, please see www.PfizerCoPay.com. Pfizer understands that your personal and health information is private and will only use your information in accordance with our Privacy Policy. The information you provide will only be used by Pfizer and parties acting on its behalf to send you the materials you requested as well as other helpful product and/or related product information, disease state information, offers, and services.

See next page to continue completing the Patient section of the Enrollment Form.

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

Read, sign, date, and return the Patient Authorization form to Pfizer enCompass. This is required to request assistance.

5. *PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Pfizer Inc., the Pfizer Patient Assistance Foundation™, Pfizer affiliates, and its vendors (collectively, "Pfizer"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Pfizer so that Pfizer may provide me with various support and information to help me access a Pfizer medicine, which may include the following (collectively, "Patient Support Activities"):

- 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
- Providing me with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs
- Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services.

I understand that I do not have to sign this form and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, Pfizer enCompass may not be able to provide me with assistance.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me. I understand that this form will remain in effect for 4 years from the date of my signature unless state law requires a shorter period, or I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact Pfizer enCompass at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067. 1-844-722-6672, Monday–Friday, 8 AM–8 PM ET. This withdrawal will not affect the use or sharing of my health information that took place before I withdrew my approval. I understand I may receive a copy of this form.

***PRINT NAME OF PATIENT**

***PATIENT SIGNATURE**
(PATIENT OR PATIENT REPRESENTATIVE)

PATIENT REPRESENTATIVE NAME
(PLEASE PRINT. REQUIRED IF SIGNING ON BEHALF OF THE PATIENT)

***DATE**

IF SIGNED BY PATIENT REPRESENTATIVE, PLEASE INDICATE BELOW THE AUTHORITY TO ACT ON BEHALF OF PATIENT:

☐ COURT APPOINTED ☐ GUARDIAN ☐ POWER OF ATTORNEY, INCLUDING AUTHORITY TO MAKE HEALTHCARE DECISIONS ☐ OTHER

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* PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)

For Healthcare Provider to Complete

1. HEALTHCARE PROVIDER INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER. ALL FIELDS MUST BE COMPLETED)

*INDICATES REQUIRED FIELDS

*PRESCRIBER NAME (FIRST/MI/LAST) | *SPECIALTY

*PRACTICE/ INSTITUTION NAME | *GROUP TAX ID NUMBER

STREET ADDRESS | *CITY | *STATE | *ZIP

*OFFICE PHONE | *OFFICE FAX | *OFFICE CONTACT

*OFFICE CONTACT PHONE NUMBER | *OFFICE CONTACT EMAIL

ADMINISTERING PROVIDER INFORMATION (IF DIFFERENT FROM REFERRING PROVIDER)

ADMINISTERING PROVIDER ADMINISTERS AND OVERSEES THE PRODUCT INFUSION. *INDICATES REQUIRED FIELDS

*ADMINISTERING PROVIDER NAME (FIRST/MI/LAST) | *SPECIALTY | *NPI #

*PRACTICE NAME | *OFFICE CONTACT

*ADDRESS | *CITY | *STATE | *ZIP

*EMAIL | *PHONE | *FAX

2. CLINICAL INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER) *INDICATES REQUIRED FIELDS

*PRIMARY DIAGNOSIS CODE | SECONDARY DIAGNOSIS CODE

DATE OF INFUSION

3. HEALTHCARE PROVIDER AND CONSENT TO RECEIVE COMMUNICATIONS

(TO BE COMPLETED BY HEALTHCARE PROVIDER) *INDICATES REQUIRED FIELDS

I give my permission to receive calls related to these services from Pfizer, Pfizer enCompass, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

*SIGNATURE OF HEALTHCARE PROVIDER | *DATE

DISCLAIMER

Insurance verification is the ultimate responsibility of the provider. Benefit information provided by Pfizer enCompass is not a guarantee of insurance coverage or reimbursement. All benefit information is subject to the insured patient's plan at the time services are rendered. Under no circumstances shall Pfizer enCompass be held responsible or liable for payment of any claims, benefits, or cost. Any coding information obtained from Pfizer enCompass is provided for informational purposes only, is subject to change, and should not be construed as legal advice. Providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to the specific patient.

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