Prescription and Patient Support Enrollment Form

PFIZER DERMATOLOGY patient access™

HCPs can go to PfizerDermatologyHCPPortal.com to complete this form online.
Questions? Call 1-833-956-3376, Monday - Friday, 8:00 AM to 8:00 PM ET.

HCPs can upload online at PfizerDermatologyHCPPortal.com | Fax completed forms to 1-877-548-1734 | HCPs can e-Prescribe directly to Sonexus Health Pharmacy Services*

SELECT PATIENT PRESCRIPTION (*Select ONE MEDICATION per enrollment form)		
CIBINQO® (abrocitinib) tablets ☐ 50 mg ☐ 100 mg ☐ 200 mg	EUCRISA® (crisaborole) ointment, 2% ☐ 60-g tube ☐ 100-g tube	LITFULO™ (ritlecitinib) capsules ☐ 50 mg

FOR PATIENTS – Complete the following sections; then, read, sign, and date (where applicable) the required authorization and consents on pages 2 and 3. Missing information or consents may cause delays in filling your prescription and signing you up for the Pfizer Dermatology Patient Access support program.

1. PATIENT INFORMATION (*REQUIRED)

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

DOB* (mm/dd/yyyy) _____ Gender ☐ M ☐ F ☐ Other

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

Primary Phone* _____ ☐ H ☐ W ☐ M

Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening

Email _____

Preferred Language (if not English) _____

Caregiver Name _____ Phone _____
(Required if patient is under 18)

2. INSURANCE INFORMATION - Insurance Type*: ☐ Commercial ☐ Government ☐ Medicare Part D ☐ Other ☐ None (*REQUIRED)

	Primary Medical Insurance*	Primary Prescription Insurance*	Secondary Prescription Insurance
	(*REQUIRED only if front and back copies of insurance card[s] are NOT provided)		
Policyholder Name*			
Insurance Name*			
Insurance Phone*			
Policy ID#*			
Group #*			
BIN #*			
PCN #*			

*If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying that you have received patient consent for Sonexus Health Pharmacy Services and Pfizer Dermatology Patient Access to contact your patient and provide them services. Sonexus Health Pharmacy Services is categorized as a mail-order pharmacy in EMR/EHR systems and is located at 2730 S. Edmonds Lane, Suite 400, Lewisville, TX 75067.

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.

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3A. PATIENT PRIVACY NOTICE AND CONSENT TO PROCESS HEALTH INFORMATION (*REQUIRED)

By checking the box below, 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 contacting Pfizer Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376). You can find more information about how Pfizer Inc. handles your personal information in our Privacy Policy at pfizer.com/privacy.

I understand that I have the right to withdraw my consent by calling [phone number], and that if I withdraw my consent 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.**

3B. PATIENT CONSENT TO RECEIVE COMMUNICATIONS (*REQUIRED)

By providing my mobile number and checking the box below, I or my caregiver agree to receive calls and texts from Pfizer or parties acting on its behalf, to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, refill reminders from Pfizer Dermatology Patient Access, 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 or my caregiver provide.

Please enter the mobile number you would like to enroll for texting _____ – _____ – _____

☐ ***I or my caregiver agree to receive calls and texts from Pfizer or parties acting on its behalf as stated.**

Consent to Receive Emails (Optional)

By providing my email address in Section 1 or below, I consent to receive program information, enrollment status, shipping updates, and refill reminders from Pfizer Dermatology Patient Access via email. Email will be one-way communication identified as Pfizer Dermatology Patient Access from a "Do Not Reply" email box. I can opt out of these emails anytime by contacting Pfizer Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376).

Email address: _____

I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376). 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. Complete terms can be found at Engagedrx.com/PDPA and Pfizer's privacy policy at www.pfizer.com/privacy. Text STOP to opt out.

3C. PATIENT ACCESS COORDINATOR (PAC) OPT-IN

When you enroll in Pfizer Dermatology Patient Access, you have the option to be contacted by a Pfizer Patient Access Coordinator (PAC), who can help you understand your insurance benefits and navigate the process to access your prescribed medication. PACs are field-based employees of Pfizer and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. PACs are very familiar with access and reimbursement requirements for CIBINQO® (abrocitinib) and LITFULO™ (ritlecitinib), and the PAC assigned to you will coordinate with Pfizer Dermatology Patient Access and you on your journey to starting therapy (although you will still need to contact Pfizer Dermatology Patient Access directly if you are seeking financial assistance). Working with a PAC is optional. Even if you choose not to opt-in for this support, you may still access all patient support programs you are eligible for by working with a patient support representative at Pfizer Dermatology Patient Access.

☐ By checking this box, I request PAC support and agree to receive telephonic communications from the PAC assigned to my case as described above. I understand that my consent is not required or a condition for purchasing any Pfizer goods or services. I understand that I can opt out of support from, and communications with, the PAC at any time by contacting Pfizer Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376).

Questions? Call 1-833-956-3376, Monday - Friday, 8:00 AM to 8:00 PM ET.

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (*REQUIRED)

By signing and dating 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 copay 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's 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 and date this form, Pfizer Dermatology Patient Access™ 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. I consent to Pfizer using my health information for the purposes described in this form or as required or permitted by 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 Dermatology Patient Access at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, or at 1-833-956-DERM (1-833-956-3376). This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I will receive a copy of this form.

SIGN X _____ _____

Patient Signature* (Patient or patient representative must be 18 or older)[†] **Date***

SIGN X _____ _____

Patient representative name (please print)[‡] 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 _____

[†]Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.

[‡]NOT required if patient signs.

[§]Required if patient representative signs.

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CHECK IF APPLICABLE ☐ BENEFITS INVESTIGATION ONLY

☐ This prescription has also been sent to a Specialty Pharmacy Provider (SPP)

SPP Name _____ SPP Phone Number _____

Patient First Name* _____ **Last Name*** _____ **Date of Birth** (mm/dd/yyyy)* _____ **(*REQUIRED)**

FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page. Fax COMPLETED form with a cover sheet to 1-877-548-1734.

4. PRESCRIBER INFORMATION (*REQUIRED)

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

NPI#* _____ **State License Number*** _____

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

Office Contact Name _____ **Office Phone Number*** _____ Ext. _____

Office Fax* _____ Email _____

5. DIAGNOSIS (*REQUIRED) – DO NOT ATTACH ANY CLINICAL OR OFFICE NOTES AS THIS MAY DELAY PROCESSING THE FORM

ICD-10 codes for CIBINQO and EUCRISA:
- ☐ L20: Atopic Dermatitis
- ☐ L20.8: Other Atopic Dermatitis
- ☐ L20.9: Atopic Dermatitis, Unspecified

ICD-10 codes for LITFULO:
- ☐ L63: Alopecia Areata
- ☐ L63.0: Alopecia (Capitis) Totalis
- ☐ L63.1: Alopecia Universalis
- ☐ L63.2: Ophiasis
- ☐ L63.8: Other Alopecia Areata
- ☐ L63.9: Alopecia Areata, Unspecified
- ☐ Other _____

6. PRESCRIPTION INFORMATION – Directions for e-Prescribing are located in Section 7 (*Select one medication per enrollment form)

Interim Care Rx for CIBINQO and LITFULO: Only filled through Sonexus Health Pharmacy Services. By requesting this, you certify that you understand the terms and conditions on page 5.

Prescription for CIBINQO® (abrocitinib) tablets
(up to 30 days, 30 tablets)
- ☐ 50 mg PO once daily Refills _____
- ☐ 100 mg PO once daily Refills _____
- ☐ 200 mg PO once daily Refills _____

Interim Care Rx for CIBINQO (11 Refills):
(up to 30 days, 30 tablets)
- ☐ 50 mg PO once daily
- ☐ 100 mg PO once daily
- ☐ 200 mg PO once daily

Voucher Rx for CIBINQO:
(One-time 30-day supply)
- ☐ 50 mg PO once daily
- ☐ 100 mg PO once daily
- ☐ 200 mg PO once daily

Prescription for LITFULO™ (ritlecitinib) capsules
(up to 28 days, 28 capsules)
- ☐ 50 mg PO once daily Refills _____

Interim Care Rx for LITFULO (11 Refills):
(up to 28 days, 28 capsules)
- ☐ 50 mg PO once daily

Prescription for EUCRISA® (crisaborole) ointment, 2%
- ☐ 60-g tube Quantity _____ Refills _____
- ☐ 100-g tube Quantity _____ Refills _____

Directions for use (please include location on body)
_____
_____

Drug Allergies ☐ No ☐ Yes (If yes, please list medication[s] and associated reaction[s]): _____

Concomitant Medications: _____

7. Healthcare Provider CERTIFICATION Prescriber Signature — NO STAMPS (*REQUIRED)

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.
I authorize Pfizer, and its affiliates, agents, representatives, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.
I also give my permission to receive calls related to Program services from Pfizer, Pfizer Dermatology Patient Access, and parties acting on their behalf.

SIGN X _____ _____ _____

Healthcare Provider Signature*: NO STAMPS | Print Name of Healthcare Provider | **Date***

***e-Prescribe ID (NCPDP: 5910206; NPI: 1447680210).** If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying that you have received patient consent for Sonexus Health Pharmacy Services and Pfizer Dermatology Patient Access to contact your patient and provide them services. Sonexus Health Pharmacy Services is categorized as a retail pharmacy in EMR/EHR systems and is located at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067.

If you are a prescriber based in New York state, please use a New York state prescription form.

CIBINQO® (abrocitinib) and LITFULO™ (ritlecitinib) Interim Care Rx 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 CIBINQO® (abrocitinib) or LITFULO™ (ritlecitinib). 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, Michigan, Minnesota, or Rhode Island. Available up to a 30-day supply. Refills are subject to limitations. Interim Care offer does not require, nor will it 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 or appeals process. 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. Patients with insurance plans who carve out coverage for the product are not eligible to participate and/or continue participation in the Interim Care Program. Continued eligibility for the program requires submission by patient's healthcare provider/patient of two appeals within the first 180 days of enrollment in the Interim Care Program (some exclusions apply). 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 2 appeals (if denied) must be submitted by patient's healthcare provider/patient within 180 days of either, 1. the benefits investigation or 2. the date a new submission is allowed by the payer, for continued eligibility in the program. Assistance may be available for up to 2 years in total, which is the lifetime maximum per patient. 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. Additional eligibility criteria may apply. Contact Pfizer Dermatology Patient Access™ at 1-833-956-DERM (1-833-956-3376) for details.

VOUCHER TERMS AND CONDITIONS FOR THE PATIENT

By redeeming this voucher, you acknowledge that you currently meet the eligibility criteria and will comply with the terms & conditions described below:

You will receive a one-time, 30-day trial supply of CIBINQO. 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 CIBINQO. 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).** 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 CIBINQO. Pfizer reserves the right to rescind, revoke, or amend this offer without notice. This voucher expires 12/31/2026.

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PFIZER DERMATOLOGY patient access™

PLEASE PROVIDE THIS PAGE TO THE PATIENT DURING THEIR VISIT

Your doctor has sent your prescription(s) to Pfizer Dermatology Patient Access™ to help you with your access to CIBINQO® (abrocitinib), LITFULO™ (ritlecitinib), or EUCRISA® (crisaborole).

Please call 1-833-956-DERM (1-833-956-3376) today

to discuss how Pfizer Dermatology Patient Access may be able to help

SCAN and save the Pfizer Dermatology Patient Access contact information to your phone.

Pfizer is not accessing data on the user's phone.

Pfizer Dermatology Patient Access will work with you to determine if you have coverage for CIBINQO, LITFULO, or EUCRISA through your insurance.

What to expect:

A Patient Support Representative from Pfizer Dermatology Patient Access will call you when your prescription is received. The number will be displayed as 1-833-956-3376 on your caller ID.

Topics discussed during the call may include:

- Requests for missing information
- Insurance coverage information
- Pharmacy preference

Once coverage through your insurance plan has been determined and approved, your medication will be either delivered to you by a specialty pharmacy or transferred to a pharmacy of your choice.

Please see full Prescribing Information, including **BOXED WARNING**, and Medication Guide for CIBINQO®, and full Prescribing Information, including **BOXED WARNING**, and Medication Guide for LITFULO™.

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