PFIZER PATIENT ASSISTANCE PROGRAM*

XELSOURCE℠
Answers and Support

PATIENT APPLICATION

Phone 1-844-935-5269 • Fax 1-866-297-3471 • 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

Please complete the form where applicable and return via mail or fax. Pages 1 and 2 must be returned to XELSOURCE.

☐ **Check here if reapplying for the Pfizer Patient Assistance Program.**

PATIENT INFORMATION	Patient Name:		
	Patient Address:		
	City:	State:	ZIP Code:
	Telephone (Day):	Telephone (Evening):	
	E-mail (Please provide to speed up process):		
	Date of Birth (DOB):		

INSURANCE INFORMATION	☐ I confirm that I do not have prescription drug coverage.

PATIENT FINANCIAL INFORMATION	**Total Number of People Within Household (including applicant):** _____ **Total Annual Income for Entire Household: $** _____ (The current annual household income includes current annual salary, Social Security, unemployment insurance benefits, and workers' compensation) **Please submit documentation to support the financial information.** **Attached is:** ☐ **Most recent federal tax return (1040 form)** ☐ **W-2 form** ☐ **Other** We must receive proof of income to determine eligibility for assistance. If you are required to file a federal tax return, please provide a signed copy. Proof of income may include documents such as: copy of most recent federal tax return, W-2 form(s), 1099 form, Social Security Award Letter or Check, or copies of three most recent pay stubs.

Patient Declaration – By signing below, I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge.

I understand that:

- Completing this application form does not guarantee that I will qualify for the Pfizer Patient Assistance Program.
- Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medications supplied by the Pfizer Patient Assistance Program shall not be sold, traded, bartered, or transferred.
- Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program at any time.
- The support provided in this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by the Pfizer Patient Assistance Program:

- I will promptly contact XELSOURCE if my financial status or insurance coverage changes.
- I will not seek to have the medicine(s) or any cost from it (them) counted in my Medicare Part D out-of-pocket expenses for prescription drugs.
- I will not seek reimbursement or credit for any costs associated with the medicine(s) from my prescription insurance provider or payer, including Medicare Part D plans.
- I will notify my insurance provider of the receipt of any medicine(s) through the Pfizer Patient Assistance Program.
- I have a signed copy of a current and complete HIPAA Authorization Form on record with my Prescriber so that my Prescriber may share health information about me with Pfizer's assistance programs, Pfizer Inc, and the Pfizer Patient Assistance Foundation, Inc.

The information you provide will be used by Pfizer, the Pfizer Patient Assistance Foundation, Inc., and parties acting on their behalf to determine eligibility, to manage and improve Pfizer programs, products, and services, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs. This information may be disclosed to entities to determine eligibility for other patient assistance programs as an alternate or supplement to your coverage for XELJANZ.

*The Pfizer Patient Assistance Program is a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc with distinct legal restrictions.

X _____

Patient Signature (Parent or Guardian, if under 18 years of age) **Date**

Click here for XELJANZ full Prescribing Information, including **BOXED WARNING** and Medication Guide.

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HCP TO COMPLETE

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PRESCRIBER INFORMATION (To be completed by the provider)	Prescriber Name & Title:		Prescriber Specialty:	
	Payer Specific #:	NPI #:	Tax ID #:	
	State License #:		DEA #:	
	Name of Facility:			
	Prescriber Address:			
	City:		State:	ZIP Code:
	Contact Name:			
	Contact Phone:		Fax:	
	Contact E-mail Address:			

PRESCRIBER CERTIFICATION

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I will notify XELSOURCE immediately if the Pfizer product is no longer medically necessary for this patient's treatment. **I certify that the Pfizer product is medically necessary for this patient and I will be supervising the patient's treatments.** I have a signed copy on file of my patient's current and completed HIPAA Authorization Form so that I may share patient health information with Pfizer's assistance programs, Pfizer Inc, and the Pfizer Patient Assistance Foundation, Inc. I understand that any information provided is for the sole use of Pfizer and their agents and representatives to verify my patient's insurance coverage, to assess, if applicable, patient's eligibility for participation in the Pfizer Patient Assistance Program and to otherwise administer XELSOURCE and related services. I understand that application to the Pfizer Patient Assistance Program does not guarantee that assistance will be obtained. I understand that Pfizer may change or cancel this program at any time. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the Pfizer Patient Assistance Program, and I agree to immediately notify a XELSOURCE representative if I become aware of changes in the patient's insurance status. I agree that Pfizer may contact me for additional information relating to this application either by fax or any other form of communication, including but not limited to e-mail and telephone. I understand that I am under no obligation to prescribe any Pfizer product and that I have not received nor will I receive any benefit from Pfizer or their agents or representatives for prescribing a Pfizer product. I agree that I will not submit claims for product provided by the Pfizer Patient Assistance Program.

The information you provide will be used by Pfizer, the Pfizer Patient Assistance Foundation, Inc., and parties acting on their behalf to administer and improve Pfizer programs, products, and services, to communicate with you about your experience with Pfizer and the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

Prescriber Signature X	Date:

SHIP TO	☐ Prescriber ☐ Patient ☐ Other (please provide shipping address—NO PHARMACIES):		
	Address:		
	City:	State:	ZIP Code:

CLINICAL AND PRESCRIPTION INFORMATION	Patient First Name:	Patient Last Name:
	Patient Date of Birth:	Patient Phone:
	Rx: ☐ XELJANZ XR 11 mg PO QD, 30-day supply XELJANZ XR is not recommended in UC. ☐ XELJANZ 10 mg PO BID, 30-day supply 10 mg is recommended only in UC. ☐ XELJANZ 5 mg PO BID, 30-day supply	Refills (up to 11):
	Drug Allergies: ☐ Yes ☐ No If yes, please list medication(s) and associated reaction(s):	
	Patient's current medication(s):	
	Prescribing Physician Signature—NO STAMPS (Dispense as written)	
	X	Date:

Note: If you are a New York prescriber, please attach state prescription form.

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Click here for XELJANZ full Prescribing Information, including **BOXED WARNING** and Medication Guide.

HIPAA Authorization Form for the Disclosure of Patient Information by Personal Physician

FOR PFIZER INC AND THE PFIZER PATIENT ASSISTANCE FOUNDATION, INC.

DO NOT SUBMIT THIS FORM WITH YOUR APPLICATION—IT IS FOR PATIENT AND PRESCRIBER RECORDS ONLY

To the Patient: Pfizer Inc and the Pfizer Patient Assistance Foundation, Inc., offer patient assistance programs (the "Program") to help patients who qualify obtain certain Pfizer medicines at no cost. In order to determine your eligibility for the Program and to administer your participation in the Program if you are accepted, Pfizer, along with its affiliated companies and contractors who administer the Program, need to obtain certain information about you from your physician (who is also called your "Doctor" in this form). Please complete this Authorization, sign and date it, and return it to your doctor.

To the Physician: Please retain the original signed Authorization with the patient's records and provide a copy to the patient. You do not need to return this patient Authorization to Pfizer.

I request and authorize my Doctor, _____ , to give Pfizer Inc, including representatives and contractors who work on behalf of Pfizer in this Program (collectively, "Pfizer"), my protected health information, including but not limited to information about my medical condition and treatments, which is necessary to determine my eligibility for the Program and for my continuing participation in the Program if I am accepted, to administer the Program, to account for my withdrawal if I decide to stop participating in this Program, and to evaluate patient satisfaction and the Program's overall effectiveness. The type of information that can be given under this authorization may include:

- My name and birth date
- My address and telephone number
- My social security number
- Financial information about me
- Information about my health benefits or health insurance coverage
- Information on my medical condition, as necessary

I understand that I may refuse to sign this authorization and that it is strictly voluntary. Further, I understand that my Doctor may not condition the provision of my treatment on my signing this authorization.

I know that I can cancel (revoke) this authorization at any time by writing to my Doctor at _____. If I cancel this authorization, then my Doctor will stop providing Pfizer, and its representatives, with information about me. However, I cannot cancel actions that have already been taken by relying on my authorization.

I understand that once my Doctor gives Pfizer information about me based on this authorization, federal privacy laws may not prevent Pfizer from further disclosing my information. I also understand that signing this authorization does not guarantee that I will be accepted into a Pfizer patient assistance program.

This authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medicines under the Program, whichever is later, or as required by state law.

Patient or Personal Representative of Patient {If personal representative, indicate authority to sign on behalf of Patient (if applicable)}

Signature _____

Date _____

Name (please print) _____

Please return the signed form to your Doctor. You are entitled to a copy for your records.

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