

 Fax completed forms to
1-860-392-3567

 Mail to Pfizer Hemophilia Connect
600 Emerson Road, 3rd Floor, Suite 300, Creve Coeur, MO 63141

 Questions? Call 1-888-733-2030
M-F, 8 AM-6 PM ET

FOR PATIENTS – Complete the following sections; then, read, sign, and date (where applicable) the required authorization and consents.
Missing information or consents may cause delays in filling your prescription and signing you up for the Pfizer Hemophilia Connect program.

1 PATIENT INFORMATION (*REQUIRED)

First Name* _____ MI _____ Last Name* _____ Date of Birth (mm/dd/yyyy)* _____
 Sex* ☐ Male ☐ Female (Sex describes one's biology at birth) Gender ☐ Male ☐ Female ☐ Other (Gender describes how one identifies oneself)
 Address* _____ City* _____ State* _____ ZIP* _____
 Primary Phone* _____ ☐ H ☐ M ☐ W Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Preferred Language if not English: _____
 Email _____ Preferred Communication: ☐ Phone ☐ Email
 Caregiver First Name _____ Caregiver Last Name _____ Phone _____ Email _____
 Caregiver Relationship to Patient: ☐ Guardian ☐ Court Appointed ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

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

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

FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page. Fax COMPLETED form with a cover sheet to 1-860-392-3567.

3 PRESCRIBER INFORMATION (*REQUIRED)

First Name* _____ Last Name* _____
 NPI #* _____ State License #* _____ Practice Name* _____
 Address* _____ City* _____ State* _____ ZIP* _____
 Office Contact First Name* _____ Office Contact Last Name* _____ Office Contact Phone* _____ Ext. _____
 Email _____ Office Fax* _____ Group Tax ID _____ Preferred Communication Method: ☐ Phone ☐ Fax ☐ Email

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

Primary ICD-10 Code* ☐ Hereditary factor VIII deficiency: D66 Hem A without inhibitors ☐ Hereditary factor IX deficiency: D67 Hem B without inhibitors

5 PREFERRED SPECIALTY PHARMACY

Preferred Specialty Pharmacy Name* _____ ☐ Self-Dispensing Pharmacy Fax* _____
 Preferred Specialty Pharmacy Street Address* _____ City* _____ State* _____ ZIP* _____

The patient identified on this form 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 to a Specialty Pharmacy approved by this patient's plan. If there is no preferred Specialty Pharmacy indicated, then to any Specialty Pharmacy approved by this patient's plan.

6 PRESCRIPTION INFORMATION

Product Form: HYMPAVZI (marstacimab-hncq) Prefilled Pen – 150 mg/mL 0069-2151-01	
Month 1 with Loading Dose: ☐ Day 1 – Administer 300 mg (two 150 mg injections) SQ; AND Day 8 and thereafter – Administer 150 mg injection SQ weekly (QTY: 5)	Dose Adjustment During Treatment Note A dose adjustment to 300 mg subcutaneous injection weekly can be considered in patients weighing ≥50 kg when control of bleeding events is judged to be inadequate by the healthcare provider.
Maintenance Months: ☐ Administer 150 mg injection SQ weekly (QTY: 4) Refills: _____	Maintenance Months with Dose Adjustment: ☐ Administer 300 mg (two 150 mg injections) SQ weekly (QTY: 8) Refills: _____
☐ Interim Care Rx - HYMPAVZI (marstacimab-hncq) Prefilled Pen – 150 mg/mL 0069-2151-01 (maximum of 12 months)	
Month 1 with Loading Dose: ☐ Day 1 – Administer 300 mg (two 150 mg injections) SQ; AND Day 8 and thereafter – Administer 150 mg injection SQ weekly (QTY: 5)	Dose Adjustment During Treatment Note A dose adjustment to 300 mg subcutaneous injection weekly can be considered in patients weighing ≥50 kg when control of bleeding events is judged to be inadequate by the healthcare provider.
Maintenance Months: ☐ Administer 150 mg injection SQ weekly (QTY: 4) Refills: _____	Maintenance Months with Dose Adjustment: ☐ Administer 300 mg (two 150 mg injections) SQ weekly (QTY: 8) Refills: _____
☐ Voucher Rx - HYMPAVZI (marstacimab-hncq) Prefilled Pen – 150 mg/mL 0069-2151-01 (maximum 1 month)	
Month 1 with Loading Dose: ☐ Day 1 – Administer 300 mg (two 150 mg injections) SQ; AND Day 8 and thereafter – Administer 150 mg injection SQ weekly (QTY: 5)	

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

7 HEALTHCARE PROVIDER CERTIFICATION Prescriber Signature—NO STAMPS

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 Hemophilia Connect, and parties acting on their behalf.

SIGN  Healthcare Provider Signature* (Dispense as Written) Healthcare Provider Signature* (Substitution Allowed) Date*

Note: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber. New York and Iowa providers, please submit electronic prescription to your preferred Specialty Pharmacy.

First name* _____ MI _____ Last name* _____ Date of Birth (mm/dd/yyyy)* _____

FOR PATIENTS

8 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 Hemophilia Connect (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 Hemophilia Connect by emailing PfizerHemophiliaConnect@pfizer.com or by calling 1-888-733-2030, 8 AM-6 PM 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 

Patient or patient representative signature* (must be 18 years or older)[†]

Patient or patient representative name (please print)[‡]

Date*

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 below can sign on their behalf.

[‡]NOT required if the patient signs.

^{*}Required if patient representative signs.

First name* _____ MI _____ Last name* _____ Date of Birth (mm/dd/yyyy)* _____

SPECIAL INSTRUCTIONS

☐ Patient Device Training Requested

A qualified instructor will provide virtual training on how to get accustomed to the device.

FOR PATIENTS

9 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 Hemophilia Connect 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 copay 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 by emailing PfizerHemophiliaConnect@pfizer.com or calling 1-888-733-2030, 8 AM-6 PM 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 is available to me upon request.

SIGN ✕

Patient or patient representative signature* (Patient or patient representative must be 18 years or older)*

Date*

SIGN ✕

Patient or patient representative name (please print)†

INTERIM CARE Rx PROGRAM TERMS & 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 HYMPAVZI™ (marstacimab-hncq). The Interim Care Program is applicable to all HYMPAVZI™ formulations. 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 or Michigan. For residents of Minnesota or Rhode Island, available for up to six months. For all other eligible patients, this program is available for a period of up to twelve months (lifetime maximum) or until they receive insurance coverage approval, whichever occurs earlier. Available in 30-day supply. Refills are subject to limitations. Continued eligibility for the program requires, 1. submission of first appeal within 60 days of enrollment (or within the required payer timeline, if sooner) in the Interim Care Program and submission of the second appeal, if allowed by the payer, within 60 days of the date of the first appeal denial (or within the required payer timeline, if sooner), 2. satisfying all payer appeal requirements and 3. patients schedule their initial prescription dispense within 60 days of enrollment. Pfizer may conduct periodic benefits investigation to determine if there is a payer coverage change. If payer coverage is identified and allowed by the payer, Pfizer may require submission of a new Prior Authorization request and appeal, if denied, within 60 days (or within the required payer timeline, if sooner) of either, 1. the date of completion of the benefits investigation, provided by the Pfizer Hemophilia Connect Program to the patient's authorized healthcare provider, or 2. the date a new submission is allowed by the payer, for continued eligibility in the program, whichever is later. Interim Care offer does not require, nor will 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 process, or an appeal is required. All payer appeal timelines must be met for continued assistance. 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. Additional eligibility criteria may apply. Contact Pfizer Hemophilia Connect at 1-888-733-2030 for details.

VOUCHER Rx TERMS & CONDITIONS

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, 28-day supply of HYMPAVZI. Only eligible new HYMPAVZI patients may use this voucher, and each patient is limited to 1 voucher.
- By redeeming this voucher, you certify that you are not currently using HYMPAVZI.
- 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).**
- You must be 18 years of age or older or be 18 years of age or older and a caregiver of a HYMPAVZI patient.
- This voucher is not valid where prohibited by law.
- This voucher cannot be combined with any other savings, free trial, or similar offers 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 HYMPAVZI.
- Pfizer reserves the right to rescind, revoke, or amend this offer without notice. This voucher expires on 12/31/2026.

MA residents may select their pharmacy. Otherwise, this free trial will be supplied through SONEXUS.

*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 the patient signs.

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.

HYMPAVZI is a trademark of Pfizer Inc.