Pfizer Inc. Pfizer enCompass® Enrollment Form for INFLECTRA® (infliximab-dyyb) for Injection

Please complete and fax this form to 1-844-482-4482 or mail to Pfizer Inc. ("Pfizer") at Pfizer enCompass, PO Box 220040, Charlotte, NC 28222
For assistance call: 1-844-722-6672, Monday–Friday, 9 AM–8 PM ET

For enrollment into the Pfizer Patient Assistance Program or Drug Replacement Program, complete the Pfizer Patient Assistance Program Application available at www.pfizerencompass.com or by calling Pfizer enCompass.

By enrolling in Pfizer enCompass, patients will receive various support and information to help access Pfizer medicine, which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assistance with prior authorization requirements from my insurer
  - Assistance with appealing any denial from my insurer
- 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

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

☐ Benefit verification and/or prior authorization support (Complete sections 1-4, 8)

☒ Pfizer enCompass Co-Pay Assistance Program (Complete sections 1-8)

☐ Referral for Interim Assistance (Complete sections 1-5, 8)

1. PATIENT INFORMATION (TO BE COMPLETED BY PATIENT) *INDICATES REQUIRED FIELDS

*NAME (FIRST, MIDDLE INITIAL, LAST) *SEX ☐ MALE ☐ FEMALE

*STREET ADDRESS *CITY *STATE *ZIP

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

LANGUAGE PREFERENCE ☐ PATIENT ☐ CAREGIVER CAREGIVER NAME CAREGIVER PHONE

2. CLINICAL INFORMATION

PRIMARY DIAGNOSIS CODE

SECONDARY DIAGNOSIS CODE

Please list all current treatments to the right and any prior treatments associated with the indications provided above.

TB/PPD TEST DATE ☐ POS ☐ NEG

HEP B TEST DATE ☐ POS ☐ NEG

List Current/Prior Treatments	Treatment Length (mm/yyyy) From	To
1. Methotrexate ☐ Y ☐ N		
2.		
3.		
4.		
5.		

3. INSURANCE INFORMATION (TO BE COMPLETED BY PATIENT OR HEALTHCARE PROVIDER) *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 NAME *INSURANCE PHONE *POLICY/GROUP NUMBER

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

SECONDARY INSURANCE

*INSURANCE NAME *INSURANCE PHONE *POLICY/GROUP NUMBER

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

PRESCRIPTION INSURANCE

PRESCRIPTION INSURANCE NAME 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.

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* PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)

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

*INDICATES REQUIRED FIELDS

*PRESCRIBER NAME (FIRST/MI/LAST)

*PRACTICE/ INSTITUTION NAME Metro Infusion Center

*SPECIALTY ID

*STREET ADDRESS

*CITY

*STATE

*ZIP

*OFFICE PHONE 630-590-2831

OFFICE FAX 630-734-4678

*OFFICE CONTACT Katie Keller

*OFFICE CONTACT PHONE NUMBER 630-590-2831

*OFFICE CONTACT EMAIL kkeller@innovativeventures.com

*GROUP TAX ID NUMBER 36-3966745

*STATE LICENSE NUMBER

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) Same as above

*SPECIALTY

*NPI #

*STATE LICENSE #

*PRACTICE NAME

*OFFICE CONTACT

*ADDRESS

*CITY

*STATE

*ZIP

*PHONE

*FAX

*EMAIL

5. BILLING ADDRESS FOR PAYMENT FROM THE PFIZER enCOMPASS CO-PAY ASSISTANCE PROGRAM, IF DIFFERENT FROM ADMINISTERING PROVIDER

*INDICATES REQUIRED FIELDS

*PRACTICE BILLING OFFICE NAME Metro Infusion Center

*PRACTICE BILLING OFFICE CONTACT Katie Keller

*PRACTICE BILLING ADDRESS 901 McClintock Drive Suite 201

*CITY Burr Ridge

*STATE IL

*ZIP 60527

*PRACTICE BILLING PHONE 630-590-2831

*EMAIL kkeller@innovativeventures.com

6. PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing this form, I agree to communications from Pfizer, Pfizer enCompass, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer, Pfizer enCompass, or parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number(s) provided. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Pfizer enCompass, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer enCompass, and/or parties acting on their behalf to contact my caregiver for such purposes. 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, 9 AM–8 PM ET.

PRINT NAME OF PATIENT*

PATIENT SIGNATURE

DATE

*Patient name or name of personal representative. If personal representative of patient, please complete the fields below.

SIGNATURE OF PERSONAL REPRESENTATIVE

DESCRIPTION OF AUTHORITY

DATE

TERMS AND CONDITIONS

By using this program, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions below:

The Pfizer enCompass Co-Pay Assistance Program for INFLECTRA is not valid for patients that are enrolled in a state or federally funded insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud"). Program offer is not valid for cash-paying patients. With this program, eligible patients may pay as little as $0 co-pay per INFLECTRA treatment, subject to a maximum benefit of $20,000 per calendar year for out-of-pocket expenses for INFLECTRA including co-pays or coinsurances. The amount of any benefit is the difference between your co-pay and $0. After the maximum of $20,000 you will be responsible for the remaining monthly out-of-pocket costs. Patient must have private insurance with coverage of INFLECTRA. This offer is not valid when the entire cost of your prescription drug is eligible to be reimbursed by your private insurance plans or other private health or pharmacy benefit programs. You must deduct the value of this assistance from any reimbursement request submitted to your private insurance plan, either directly by you or on your behalf. You are responsible for reporting use of the program to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the program, as may be required. You should not use the program if your insurer or health plan prohibits use of manufacturer co-pay assistance programs. This program is not valid where prohibited by law. This program cannot be combined with any other savings, free trial or similar offer for the specified prescription. **This program is not health insurance.** This program is good only in the U.S. and Puerto Rico. This program is limited to 1 per person during this offering period and is not transferable. No other purchase is necessary. Data related to your redemption of the program assistance may be collected, analyzed, and shared with Pfizer, for market research and other purposes related to assessing Pfizer's programs. Data shared with Pfizer will be aggregated and de-identified; it will be combined with data related to other assistance redemptions and will not identify you. Pfizer reserves the right to rescind, revoke or amend this program without notice. This program may not be available to patients in all states. For more information about Pfizer, visit www.pfizer.com. For more information about the Pfizer enCompass Co-Pay Assistance Program, call Pfizer enCompass at 1-844-722-6672, or write to Pfizer enCompass Co-Pay Assistance Program, P.O. Box 220040, Charlotte, NC 28222. Program terms will expire at the end of each calendar year. Before the calendar year ends, you will receive information and eligibility requirements for continued participation.

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* PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)

7. PATIENT CONSENT AND ATTESTATION IF REQUESTING 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 authorize the Pfizer enCompass Co-Pay Assistance Program for INFLECTRA to provide payment directly to my healthcare provider, and not to me, for my out-of-pocket drug costs for INFLECTRA. I authorize my healthcare provider to contact the Program on my behalf to initiate payment for services after they have been rendered. I understand that I will be responsible for any out-of-pocket expenses for INFLECTRA if (1) my healthcare provider does not request payment within 120 days of the issue date on my Explanation of Benefits (EOB), or (2) if I am deemed ineligible for reimbursement from the Program. To be eligible for this program, you must be commercially insured and not be enrolled in a state- or federally funded insurance program.
Please see full terms and conditions.

☒ 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 health care, 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 attest that I do not have End Stage Renal Disease (ESRD). I further attest that I am not active duty military nor are any of my immediate family members.

PRINT NAME OF PATIENT* | **PATIENT SIGNATURE** | **DATE**

*Patient name or name of personal representative. If personal representative of patient, please complete the fields below.

SIGNATURE OF PERSONAL REPRESENTATIVE | **DESCRIPTION OF AUTHORITY** | **DATE**

8. HEALTHCARE PROVIDER HIPAA AND TELEPHONE CONSUMER PROTECTION ACT (TCPA) ATTESTATION
(TO BE COMPLETED BY HEALTHCARE PROVIDER)

By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pfizer and its employees or agents for purposes relating to Pfizer's patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for INFLECTRA.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, Pfizer enCompass, and/or parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also 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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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, depending on your program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assistance with prior authorization requirements from my insurer
  - Assistance with appealing any denial from my insurer
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Sending me a device and starter kit (where appropriate)
- 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. However, Pfizer agrees to protect my health information and to use it 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 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 PO Box 220040, Charlotte, NC 28222, 1-844-722-6672, Monday–Friday, 9 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.

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PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I also give my permission to receive communications 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 to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Pfizer enCompass, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer enCompass, and/or parties acting on their behalf to contact my caregiver for such purposes. 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, 9 AM–8 PM ET.

PRINT NAME OF PATIENT*	PATIENT SIGNATURE	DATE

*Patient name or name of personal representative. If personal representative of patient, please complete the fields below.

SIGNATURE OF PERSONAL REPRESENTATIVE	DESCRIPTION OF AUTHORITY	DATE