XELSOURCE℠
Answers and Support

PRESCRIPTION INFORMATION AND XELSOURCE ENROLLMENT FORM

FOR USE WITH APPROPRIATE RHEUMATOID ARTHRITIS OR PSORIATIC ARTHRITIS PATIENTS ONLY

Please complete and fax this form, along with a fax cover sheet, to 1-866-297-3471.

For assistance or additional information, call 1-844-935-5269, Monday–Friday, 8 AM–8 PM ET

BENEFITS INVESTIGATION ONLY

Check and sign here if you are ONLY requesting a summary of your patient's benefits.
For full programs including prescription fulfillment, please sign prescription below.

☐ XELJANZ® XR (tofacitinib) extended release ☐ XELJANZ® (tofacitinib)

X _____ Date _____

❶ Patient Information

Name (First, MI, Last) _____ DOB (mm/dd/yyyy) _____ Gender: ☐M ☐F

Address _____ City _____ State _____ ZIP Code _____

Primary Phone _____ ☐H ☐W ☐M Alternate Phone _____ ☐H ☐W ☐M

E-mail _____ Best time to reach me: ☐Morning ☐Afternoon ☐Evening

Preferred language (if not English) _____ U.S./Puerto Rico/Guam/U.S.V.I. Resident: ☐Yes ☐No

Caregiver Name _____ Caregiver Phone _____ ☐H ☐W ☐M

❷ Insurance Information for Prescription Coverage

Please attach copies of both sides of patient's insurance card(s).

☐ **CHECK IF PATIENT DOES NOT HAVE PRESCRIPTION COVERAGE** ☐ **CHECK IF PATIENT HAS SECONDARY PRESCRIPTION COVERAGE**

Primary Prescription Insurance _____ Insurance Phone _____ Policy ID # _____

Group # _____ Policy Holder Name (First, Last), DOB, and Relationship to Patient _____

Prescription Drug Insurer _____ Patient's Preferred Pharmacy _____

Policy ID # _____ Group # _____ Rx BIN # _____ Rx PCN # _____

❸ Patient Authorization

to enroll in XELSOURCE and use of Protected Health Information.

Patient should read the Patient Authorization on the attached Patient Copy and sign. My signature certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Pfizer Inc, its affiliates, agents, representatives, and service providers to enroll me in XELSOURCE as described in the attached Patient Copy. I understand that the information I provide will be used by XELSOURCE, Pfizer, and/or parties acting on its behalf to determine my eligibility and provide benefit verification and payment assistance services. I agree to be contacted by XELSOURCE, Pfizer, and parties acting on its behalf for these purposes using an autodialer or prerecorded voice at the telephone number provided. I understand that I can opt out of receiving these communications at any time by contacting XELSOURCE at 1-844-935-5269.

☐ I give permission for XELSOURCE to share information with me via voicemail about the status of my enrollment and prescription.

☐ I certify that I am not a resident of any of the following states: MA, MI, MN, MO, OH, RI.

☐ I give permission for XELSOURCE to send me e-mail communications regarding XELSOURCE.

_____ _____
Patient Name Date

X _____ _____
Signature: Patient/Certification of person legally authorized to sign for patient Relationship

❹ Prescriber Information

Prescriber Name (First, Last) _____ Specialty _____

Prescriber NPI # _____ Group Tax ID # _____ State License # _____

Practice Name _____ Office Contact _____

Address _____ City _____ State _____ ZIP Code _____

E-mail _____ Phone _____ Fax _____

❺ Clinical Information

Please attach any clinical or office notes relevant to therapy.

☐ Rheumatoid arthritis with rheumatoid factor: **M05.** _____ (Complete the ICD-10-CM code)

☐ Other rheumatoid arthritis: **M06.** _____ (Complete the ICD-10-CM code)

☐ Arthropathic psoriasis, unspecified: **L40.50**

☐ Distal interphalangeal psoriatic arthropathy: **L40.51** ☐ Psoriatic arthritis mutilans: **L40.52**

☐ Psoriatic spondylitis: **L40.53** ☐ Other psoriatic arthropathy: **L40.59**

Date of Diagnosis or Years with Disease _____

TB/PPD Test Date _____ ☐POS ☐NEG

Hep B Test Date _____ (optional) ☐POS ☐NEG

Allergies _____

Current/Prior Medication(s)	Treatment Length (mm/yyyy)	Reason for Discontinuation (if applicable)
☐ Methotrexate - Oral	–	
☐ Methotrexate Injection, USP	–	
	–	
	–	

Additional Medical Justification _____

☐ Yes ☐ No Do you consent to being contacted by the Pfizer Drug Safety Unit for follow-up on intolerance or inadequate responses or other side effects that you may have mentioned on products listed in this form or attachments? You will be contacted if you do not provide a response.

❻ Prescription Information

Be sure to check the appropriate Rx, fill in # of refills, and sign.

Prescription for XELJANZ tablets Refills #: _____

☐ **Once Daily XELJANZ XR:** 11 mg PO, Quantity #30 (30 days)

☐ **Twice Daily XELJANZ:** 5 mg PO, Quantity #60 (30 days)

Free XELJANZ Rx Offer – Only filled through Sonexus Health Pharmacy Services. For commercially insured patients only (not available for Medicare, Medicaid, or other federal or state healthcare programs or in MA, MI, MN, MO, OH, RI).

Interim Care Rx*: ☐ 11 mg XR PO QD (up to 30 days, 30 tablets), 5 refills
☐ 5 mg PO BID (up to 30 days, 60 tablets), 5 refills

If eligible, treatment may be provided at no cost if a delay occurs in the coverage determination process. Limits, terms and conditions apply.

PLEASE NOTE: By signing this form, I certify that therapy with XELJANZ/XELJANZ XR is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current XELJANZ/XELJANZ XR Prescribing Information. I have received the necessary authorization to release medical and/or other patient information relating to XELJANZ/XELJANZ XR therapy to Pfizer Inc and its affiliates, agents, representatives, and service providers to use and disclose as necessary to enroll my patient in the XELSOURCE program. I have informed my patient or their caregiver that I will provide his/her contact information to XELSOURCE and I have received prior express consent from my patient or their caregiver for XELSOURCE, Pfizer, or parties acting on their behalf to contact my patient or their caregiver, including calls made with an autodialer or prerecorded voice, to provide information about insurance benefits and/or payment assistance services for which they may be eligible. I also give my permission to receive calls related to these services from XELSOURCE, Pfizer, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided. I further authorize XELSOURCE to fulfill the prescription below or forward it to a pharmacy based upon patient request, and (as applicable) to assess my patient's eligibility for patient assistance.

X _____
Doctor/Prescriber Signature – NO STAMPS (dispense as written) Date
If you are a New York prescriber, please use an original New York State prescription form.

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

*See accompanying Terms and Conditions on page 3.

PATIENT COPY

PROVIDER INSTRUCTIONS

- ❶ **Have the patient read this form and sign the acknowledgement on the front of the Prescription Information and XELSOURCE℠ Enrollment Form (P&E Form) relating to the Patient Authorization and XELSOURCE Extended Programs Enrollment Information.**
- ❷ **Provide the patient with this sheet and a copy of the front and back of the P&E Form which they have signed.**
- ❸ **Fax the P&E Form to XELSOURCE at 1-866-297-3471.**

PATIENT AUTHORIZATION (PA)

My signature on the front of the Prescription Information and XELSOURCE Enrollment Form confirms that:

1. Disclosure of Protected Health Information to Pfizer Inc for XELSOURCE

I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription, and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my protected health information, including but not limited to information and medical records related to my medical condition and treatment associated with my prescription for XELJANZ® (tofacitinib)/XELJANZ® XR (tofacitinib) extended release; my health insurance coverage; and my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to Pfizer Inc and its present or future affiliates, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers (including but not limited to Sonexus Health Pharmacy Services, and its affiliates, and specialty pharmacies) supporting XELSOURCE and other Pfizer Inc patient assistance programs (together, "Pfizer Inc" or alternatively, the "Pfizer Patient Assistance Foundation").

Specifically, I authorize Pfizer Inc to receive, use, and disclose my Protected Health Information in order to: (i) enroll me in XELSOURCE and contact me, and/or the person legally authorized to sign on my behalf, about XELSOURCE; (ii) provide me, and/or the person legally authorized to sign on my behalf, with educational materials, information, and programs related to XELJANZ/XELJANZ XR; (iii) verify, investigate, assist with, and coordinate my coverage for XELJANZ/XELJANZ XR, including but not limited to communicating with my Insurer, specialty pharmacies, and others involved in processing my pharmacy claims to verify my coverage; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to XELJANZ/XELJANZ XR.

2. Use of Protected Health Information to Provide Marketing Communications and Information Related to XELSOURCE

☐ I authorize any specialty pharmacy that receives my prescription to use my Protected Health Information to provide me with marketing communications and information related to XELSOURCE, including providing certain adherence messages. I acknowledge that these specialty pharmacies may receive compensation from Pfizer Inc for their services and costs incurred in connection with providing such marketing communications and information.

I understand that my Protected Health Information will not be used or disclosed by Pfizer Inc for any purposes other than as described here, unless permitted or required by law, or unless information that specifically identifies me is removed.

I understand that Pfizer Inc will make every effort to keep my Protected Health Information private. Nonetheless, I understand that once my Protected Health Information has been disclosed to Pfizer, it may no longer be protected by the federal privacy standards. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. If my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed under these circumstances and provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Patient Authorization. My choice about whether to sign will not change the way my Healthcare Providers furnish treatment to me nor will it alter my eligibility for benefits offered by my Insurers. However, if I refuse to sign this Authorization, or revoke my authorization later, I understand that this means I will not be able to participate in or receive assistance from XELSOURCE.

This Authorization will expire ten (10) years after the date it is signed on the front of the Prescription Information and XELSOURCE Enrollment Form.

I understand that I may cancel (revoke) this Authorization at any time by mailing a letter to XELSOURCE, 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067. I can also revoke my authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Pfizer Inc, but this will not affect Pfizer Inc's ability to use and disclose Protected Health Information that was already disclosed to it under this Authorization.

Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have disclosed to Pfizer Inc.

OPT-IN FOR OTHER MATERIALS

☐ By checking this box, I agree to allow Pfizer Inc, or parties acting on its behalf, to send me materials and other helpful information on my condition and XELJANZ/XELJANZ XR, as well as related treatments, products, offers, and programs.

Your name, address, and other information that you give us will be used by Pfizer Inc, the marketer of XELJANZ/XELJANZ XR, and companies that work with Pfizer Inc, including vendors and other affiliates, to support the Program. Pfizer Inc understands that your personal health information is private. Pfizer Inc will not share your information with anyone else except as stated above and as required by law. If you want to stop receiving this information from Pfizer Inc, you may ask us to remove you from our contact list by calling 1-844-935-5269.

Please read the Indications for XELJANZ and discuss any questions you have with your doctor.

Disclaimer

Pfizer's program provider performing XELSOURCE support programs provides patient insurance benefit verification as a program under contract for Pfizer Inc. XELSOURCE support programs assist patients in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Many factors affect third-party reimbursement. Pfizer Inc and Pfizer's program provider performing the XELSOURCE support programs make no representation or guarantee that insurance reimbursement or any other payment will be available. This information is provided as an information service only. While Pfizer's program provider performing XELSOURCE support programs tries to provide correct information, it and Pfizer Inc make no representations or warranties, expressed or implied, as to the accuracy of the information. The support programs administrator, or Pfizer Inc, or its employees or agents shall in no event be liable for any damages resulting from or relating to the programs. Responsibility for the use of this program is agreed upon and accepted by all providers and other users of this information.

Pfizer Inc does not guarantee, and assumes no responsibility for, the quality, scope, or availability of the XELSOURCE support programs including but not limited to reimbursement support programs, patient education, and other support programs. XELSOURCE support programs are included within the cost of the product, and have no independent value to providers apart from the product.

Interim Care Rx Program Terms & Conditions

Interim Care Rx 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 XELJANZ. 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 government plans such as 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, Missouri, Ohio, or Rhode Island. Available in 30-day supply. Refills are subject to limitations. Interim Care Rx 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 Rx can only be dispensed by the exclusive pharmacy and only after benefits investigation has been completed and a delay occurs in the prior authorization or appeals process. Offer good only in the US and Puerto Rico. Prescription must be provided by a healthcare provider licensed in the US or Puerto Rico. Additional eligibility criteria may apply. Contact XELSOURCE for details.

Co-pay Card Terms And Conditions

By using the XELJANZ® (tofacitinib)/XELJANZ® XR (tofacitinib) extended release Co-pay Savings Card (the "Card"), you acknowledge that you currently meet the eligibility criteria and will comply with the following terms and conditions.

Patients are not eligible to use this card if they are enrolled in a state- or federally-funded insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veteran 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"). Patient must have private insurance. Offer is not valid for cash paying patients. You will receive a maximum benefit of $15,000 per calendar year, which is defined by the date of enrollment through December 31st of the enrollment year, and may pay as little as $0 per month co-pay. After a maximum of $15,000, you will be responsible for paying the remaining monthly out-of-pocket costs. This Card is not valid when the entire cost of your prescription drug is eligible to be reimbursed by your private insurance plan or other private health or pharmacy benefit programs. You must deduct the value of this coupon from any reimbursement request submitted to your insurance plan, either directly by you or on your behalf. You are responsible for reporting use of the Card to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the Card, as may be required. You should not use the Card if your insurer or health plan prohibits use of manufacturer Cards. You must be 18 years of age or older to redeem the Card. The Card is not valid where prohibited by law. The Card cannot be combined with any other savings, free trial, or similar offer for the specified prescription. **The Card will be accepted only at participating pharmacies. If your pharmacy does not participate, you may be able to submit a request for a rebate in connection with this offer. The Card is not health insurance.** Offer good only in the US and Puerto Rico. The Card is limited to 1 per person during this offering period and is not transferable. The Card may be used once per month for the life of the program. No other purchase is necessary. Data related to your redemption of the Card 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 Card redemptions and will not identify you. Pfizer reserves the right to rescind, revoke, or amend the program without notice. Card and Program expires 12/31/2019. If you have questions or are in need of additional support, call 1-844-935-5269 or visit www.XELJANZ.com.

Pfizer Patient Assistance Program Eligibility Criteria

The Pfizer Patient Assistance Program is not health insurance and is available for eligible uninsured/underinsured patients only. Offer is only available to patients who meet financial and other criteria. This offer does not require, nor will it be made contingent on, purchase requirements of any kind. No claim for reimbursement or credit for any costs associated with the medicine(s) may be submitted to any prescription insurance provider or payer, including Medicare Part D plans. Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification. Offer good only in the US and Puerto Rico. Patient must be a resident of the United States or Puerto Rico. Prescription must be provided by a healthcare provider licensed in the US or Puerto Rico. Patient must be treated in the outpatient setting of care. Additional eligibility criteria may apply. Contact XELSOURCE for details.

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