FLEXCARE SPECIALTY SERVICES

Thank you for your referral for CIBINQO

(for Dermatology indications).

REQUIRED DOCUMENTATION

Please send the following items to initiate the new prescription process:

- ☑ Manufacturer form (attached), complete with FlexCare Specialty Services identified as the preferred specialty pharmacy
- ☑ Patient Demographics
- ☑ Insurance Card
- ☑ Recent Clinicals & Labs
- ☑ Medication List
- ☑ Tried/Failed Therapies
- ☑ Negative TB Results

INSTRUCTIONS

1. Please send the completed forms to us for processing.
2. You may also send the completed forms to the manufacturer, if enrollment into the manufacturer's monitoring program is desired.

PHONE: 866-205-4239 | FAX: 855-222-2514
Email: referrals@flexcarespecialty.com | visit: flexcareinfusion.com/referrals

Prescription and Patient Enrollment Form

PFIZER DERMATOLOGY patient access

Please complete and fax pages 1, 2, and 3 of this form, along with a cover sheet, to Pfizer Dermatology Patient Access™ at 1-877-548-1734. For assistance or additional information, call 1-844-496-8707, Monday-Friday, 8:00 AM to 8:00 PM ET.

SPECIAL INSTRUCTIONS—Check all that apply based on the patient's needs

☐ Benefits Investigation ONLY – pages 1, 2, and 3 must be completed in their entirety, even if you are ONLY requesting a Benefits Investigation (BI). To avoid having to provide a new prescription upon BI completion, also complete Section 5 and Pfizer Dermatology Patient Access can move forward after a decision is made.

CIBINQO™ (abrocitinib) tablets ☐ 50 mg ☐ 100 mg ☐ 200 mg

EUCRISA® (crisaborole) ointment, 2% ☐ 60-g tube ☐ 100-g tube

1. PATIENT INFORMATION (To be completed by the patient)

First Name _____ Middle Name _____ Last Name _____

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

2. PRESCRIPTION INSURANCE INFORMATION (To be completed by the patient or healthcare provider)

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

☐ **CHECK HERE IF PATIENT DOES NOT HAVE INSURANCE** ☐ **CHECK HERE IF PATIENT HAS SECONDARY INSURANCE**

Primary Insurance

Primary Insurance Name _____ Primary Insurance Phone Number _____

Policyholder Name _____ Policy # _____ Group # _____

Policyholder Relationship to Patient _____ Policyholder DOB _____

Prescription Insurance

Prescription Insurance _____ Rx Policy ID # _____

Rx Group ID # _____ Rx BIN _____ Rx PCN _____

Preferred Pharmacy and Address FlexCare Specialty Pharmacy ☑ Self-Dispensing Pharmacy

6671 SW Freeway, Ste 800, Houston, Texas 77074 Phone# 866-205-4239 Fax# 855-222-2514

The patient identified above prefers use of the pharmacy indicated above. I authorize Pfizer and its affiliates, agents, representatives, and service providers to fax this prescription to the pharmacy designated above, provided it is approved by this patient's plan. If the pharmacy designated is not a plan-approved pharmacy, then to a pharmacy approved by this patient's plan. If there is no preferred pharmacy indicated, then to any pharmacy approved by this patient's plan.

3. PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing this form, I agree to communications from Pfizer, Pfizer Dermatology Patient Access, 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 copay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer, Pfizer Dermatology Patient Access, 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 Dermatology Patient Access, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Dermatology Patient Access, 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 Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376).

☐ By checking this box and providing my cellular number, I consent to receive enrollment status, shipping updates, and refill reminders from Pfizer Dermatology Patient Access via text message. I will receive a welcome text asking me to reply YES to opt in. See terms and conditions for mobile messaging at Engagedrx.com/PDPA and Pfizer's Privacy Policy at Pfizer.com/privacy. Up to 10 messages/month. Message and data rates may apply. Text HELP to 82000 for information and STOP to opt out.

Please enter the number you would like to enroll for texting (_____) _____ - _____ .

X _____

Print Name of Patient

X _____

Patient/Caregiver Signature Date

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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Patient Full Name _____ Patient DOB (mm/dd/yyyy) _____

4. HEALTHCARE PROVIDER INFORMATION (All fields must be completed by the healthcare provider)

Prescriber Name (First/MI/Last) _____

Specialty _____ State License Number _____

Practice Name _____ NPI# _____

Street Address _____ City _____ State _____ ZIP _____

Office Contact _____ Office Phone Number _____

Fax Number _____ Email _____

5. CLINICAL INFORMATION (To be completed by the healthcare provider)

Primary Diagnosis _____ ICD-10 _____

DO NOT ATTACH ANY CLINICAL OR OFFICE NOTES AS THIS MAY DELAY PROCESSING THE FORM.

6. PRESCRIPTION Directions for e-Prescribing are located in section 7

Prescription for CIBINQO™ (abrocitinib) tablets

- ☐ 50 mg PO once daily Quantity _____ Refills _____
- ☐ 100 mg PO once daily Quantity _____ Refills _____
- ☐ 200 mg PO once daily Quantity _____ Refills _____

Interim Care Rx for CIBINQO: Only filled through Sonexus Health Pharmacy Services. See page 4 for limits, terms, and conditions.

Interim Care Rx (11 Refills):

- ☐ 50 mg PO once daily (up to 30 days, 30 tablets)
- ☐ 100 mg PO once daily (up to 30 days, 30 tablets)
- ☐ 200 mg PO once daily (up to 30 days, 30 tablets)

If eligible, treatment may be provided at no cost if a delay occurs in the coverage determination process. 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)

Prescription for EUCRISA® (crisaborole) ointment, 2%

- ☐ 60-g tube Quantity_____ Refills _____
- ☐ 100-g tube Quantity_____ Refills _____

Directions for use (please include location on body)

_____

_____

7. HEALTHCARE PROVIDER HIPAA CONSENT AND TCPA ATTESTATION

Prescriber Signature (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.

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 copay support or free drug programs, for which the patient may be eligible, and other support for CIBINQO or EUCRISA.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, Pfizer Dermatology Patient Access, 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 Dermatology Patient Access, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

X _____

Prescriber Signature: NO STAMPS (Dispense as Written) Date

X _____

Prescriber Signature: NO STAMPS (Substitution Allowed) Date

X _____

Print Name of Healthcare Provider

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.

Patient Authorization to Share Health Information

PFIZER DERMATOLOGY patient access

Please fax this completed form, along with pages 1 and 2 and a cover sheet, to Pfizer Dermatology Patient Access™ at 1-877-548-1734. For assistance or additional information, call 1-844-496-8707, Monday - Friday, 8:00 AM to 8:00 PM ET.

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 (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 our 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 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. 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 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 may receive a copy of this form. I also give my permission to receive communications from Pfizer, Pfizer Dermatology Patient Access, 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 copay 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 Dermatology Patient Access, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Dermatology Patient Access, 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 Dermatology Patient Access at 1-833-956-DERM (1-833-956-3376).

X _____

Signature of Patient/Caregiver Date

CIBINQO™ (abrocitinib) Interim Care Rx Program: TERMS AND 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 CIBINQO™ (abrocitinib). 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, Missouri, Ohio, or Rhode Island. Available up to a 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 U.S. and Puerto Rico. Prescription must be provided by a healthcare provider licensed in the U.S. or Puerto Rico. Continued eligibility for the program requires submission of two appeals within 180 days of enrollment. After 12 months of 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.

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) 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

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

What to expect:

A 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 for CIBINQO, including BOXED WARNING and Medication Guide, at CIBINQO.com.

