



Thank you for your referral for **LITFULO**  
(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.

Notice: This message and any attached documents may contain confidential and privileged information and/or protected health information ("PHI") from the sender for the use of the recipient listed above. If you are not the intended recipient, you may not read, copy, distribute, disclose or use this communication or the information contained within it. If you have received this communication in error, please notify the sender immediately and destroy the material in its entirety, whether in electronic or hard copy format. All PHI is confidential and subject to HIPAA laws and regulations.

Please complete and fax pages 1-4, along with a cover sheet, to Pfizer Dermatology Patient Access™ at 1-877-548-1734.

- Pages 1-3 are to be completed by the **patient**, and page 4 is to be completed by the **healthcare provider**.
- For assistance or additional information, call 1-844-496-8707, Monday - Friday, 8:00 AM to 8:00 PM ET.

SELECT PATIENT PRESCRIPTION	
CIBINQO™ (abrocitinib) tablets <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg	LITFULO™ (ritlecitinib) capsules <input type="checkbox"/> 50 mg
EUCRISA® (crisaborole) ointment, 2% <input type="checkbox"/> 60-g tube <input type="checkbox"/> 100-g tube	

**CHECK IF APPLICABLE**  BENEFITS INVESTIGATION ONLY

This prescription has also been sent to a Specialty Pharmacy Provider (SPP)

SPP Name \_\_\_\_\_ SPP Phone Number \_\_\_\_\_

### 1. PATIENT INFORMATION

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

DOB (mm/dd/yyyy) \_\_\_\_\_ Gender  M  F  Other

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Primary Phone \_\_\_\_\_  H  W  M Alternate Phone \_\_\_\_\_  H  W  M

Email \_\_\_\_\_ 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

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

**CHECK INSURANCE TYPE:**  Commercial  Medicare  Medicaid  Other \_\_\_\_\_  None

**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 \_\_\_\_\_  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.



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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
• 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. I consent to Pfizer using my health information 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.

X
Patient Signature Print Name of Patient Date

X
Patient Representative Signature Print Name of Patient Representative Date

If signed by patient representative, please indicate below the authority to act on behalf of patient:

- Court Appointed  Guardian  Power of Attorney, including authority to make healthcare decisions
 Other

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Patient Full Name (Required) \_\_\_\_\_ Patient DOB (Required) (mm/dd/yyyy) \_\_\_\_\_

## 4. HEALTHCARE PROVIDER INFORMATION

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

Primary ICD-10 Diagnosis Code \_\_\_\_\_

**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

<p><b>Prescription for CIBINQO™ (abrocitinib) tablets</b></p> <p><input type="checkbox"/> 50 mg PO once daily    Quantity _____ Refills _____</p> <p><input type="checkbox"/> 100 mg PO once daily    Quantity _____ Refills _____</p> <p><input type="checkbox"/> 200 mg PO once daily    Quantity _____ Refills _____</p>	<p><b>Interim Care Rx for CIBINQO and LITFULO:</b> Only filled through Sonexus Health Pharmacy Services. See page 5 for limits, terms, and conditions.</p> <p><b>Interim Care Rx for CIBINQO (11 Refills):</b></p> <p><input type="checkbox"/> 50 mg PO once daily (up to 30 days, 30 tablets)</p> <p><input type="checkbox"/> 100 mg PO once daily (up to 30 days, 30 tablets)</p> <p><input type="checkbox"/> 200 mg PO once daily (up to 30 days, 30 tablets)</p>
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<p><b>Prescription for LITFULO™ (ritlecitinib) capsules</b></p> <p><input type="checkbox"/> 50 mg PO once daily    Quantity _____ Refills _____</p>	<p><b>Interim Care Rx for LITFULO (11 Refills):</b></p> <p><input type="checkbox"/> 50 mg PO once daily (up to 28 days, 28 capsules)</p>
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<p><b>Prescription for EUCRISA® (crisaborole) ointment, 2%</b></p> <p><input type="checkbox"/> 60-g tube    Quantity _____ Refills _____</p> <p><input type="checkbox"/> 100-g tube    Quantity _____ Refills _____</p>	<p><b>Directions for use</b> (please include location on body)</p> <p>_____</p> <p>_____</p>
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## 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, LITFULO, 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** \_\_\_\_\_ **X** \_\_\_\_\_  
 Prescriber Signature: NO STAMPS (Dispense as Written)    Date    Prescriber Signature: NO STAMPS (Substitution Allowed)    Date

**X** \_\_\_\_\_  
 Print Name of Healthcare Provider (Required)

**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.

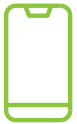
If you are a prescriber based in New York state, please use a New York state prescription form.

**CIBINQO™ (abrocitinib) and LITFULO™ (ritlecitinib) 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) or LITFULO™ (ritlecitinib). 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, 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.

**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), LITFULO™ (ritlecitinib), 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**



• **SCAN** and save the Pfizer Dermatology Patient Access contact information to your phone.

Pfizer is not accessing data on the user's phone.

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

**What to expect:**

A Patient 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](#), including **BOXED WARNING**, and [Medication Guide](#) for CIBINQO™, and full [Prescribing Information](#), including **BOXED WARNING**, and [Medication Guide](#) for LITFULO™.