Velsipityforme
PATIENT SUPPORT PROGRAM

Program Enrollment Form

VELSIPITY™ (etrasimod)

Please complete and fax pages 1-4, along with a cover sheet, to VelsipityForMe at 1-646-862-9655.

- 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 1-800-350-3080, Monday - Friday, 8:00 AM to 8:00 PM ET.

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

SPP Name _____ SPP Phone Number _____

1 PATIENT INFORMATION (*REQUIRED) Complete all required fields

First Name* _____ Middle Name _____

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)

US/Puerto Rico/USVI/Guam Resident* ☐ Y ☐ N

Address* _____

City* _____ State* _____ ZIP* _____

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

Permission to leave a Voicemail*: ☐ Y ☐ N Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Preferred Language: ☐ English ☐ Spanish ☐ Other

Email* _____

(Required to access VelsipityForMe Patient Portal)

Preferred Communication Channel*: ☐ Portal Notifications ☐ Phone ☐ Email

CAREGIVER

First Name* _____ Last Name* _____

Caregiver Relationship to Patient*:

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

☐ Other _____

Address ☐ Same as Patient _____

City _____ State _____ ZIP _____

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

Permission to leave a Voicemail*: ☐ Y ☐ N Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Preferred Language: ☐ English ☐ Spanish ☐ Other

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2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

2 INSURANCE INFORMATION (*REQUIRED)

Insurance Type: ☐ Commercial ☐ Government ☐ Other _____ ☐ None

Please provide a copy of each insurance card(s) front and back for the information requested below

	Primary Medical Insurance	Primary Prescription Insurance	Secondary Prescription Insurance
Insurance Name*			
Phone*			
Policy ID #*			
Group #*			
Policyholder Name*			
Relationship to Patient			
Policyholder DOB			
Rx BIN #*			
Rx PCN #*			

Preferred Pharmacy _____

Address _____ City _____ State _____ ZIP _____

For all insurance plans identified, 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 (*REQUIRED)

By signing this form, I agree to communications from Pfizer, VelsipityForMe, 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, VelsipityForMe, or parties working on their behalf for these purposes using text messages via 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, VelsipityForMe, and/or parties acting on their behalf for the purposes described above, and hereby gives his or her permission for Pfizer, VelsipityforMe, and/or parties acting on their behalf to contact him or her for such purposes at the phone number(s) provided. I understand that I (and, if applicable, my caregiver) can opt-out of these communications at any time by contacting VelsipityForMe at 1-800-350-3080.

☐ Yes ☐ No

By providing my cellular number, I consent to receive enrollment status, shipping updates, and refill reminders from VelsipityForMe via text message. I may receive a text message asking me to reply YES to opt-in. Up to 10 messages/month. Message and data rates may apply. Complete terms can be found at https://velsipityforme.pfizer.com/sms-terms and Pfizer's privacy policy at www.pfizer.com/privacy. STOP to opt out.

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

X _____ _____ _____
Patient Signature **Print Name of Patient** **Date**

X _____ _____ _____
Patient Representative Signature **Print Name of Patient Representative** **Date**

(Required if you have a Patient Representative who will be communicating with VelsipityForMe)

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 _____

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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4 PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (*REQUIRED)

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:
  - 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
- Providing assistance with coordinating baseline assessment/prescreening tests if I've requested and am 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 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, VelsipityForMe 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 state law requires a shorter period or unless I provide written notice that I would like to withdraw my approval to share my health information sooner. You may withdraw your consent at any time. If I would like to withdraw my approval, I may contact my physician or I may contact VelsipityForMe at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, Monday–Friday, 8 AM–8 PM ET, M–F or at 1-800-350-3080. 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.

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* _____ Patient DOB* (mm/dd/yyyy) _____

5 PRESCRIBER INFORMATION (*REQUIRED)

First* _____ Middle _____ Last* _____ Specialty* _____

NPI #* _____ State License #* _____

Practice Name* _____ Office Contact* _____ Office Fax* _____

Address* _____ City* _____ State* _____ ZIP* _____

Email* _____ Office Contact Phone* _____ Ext. _____

Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening Primary Phone _____ ☐ M ☐ H ☐ W

Preferred Communication Channel: ☐ Portal Notifications ☐ Phone ☐ Fax ☐ Email Preferred Language ☐ English ☐ Spanish

6 BASELINE ASSESSMENTS (*REQUIRED FIELD) – COMMERCIALLY INSURED PATIENTS ONLY†

Are you requesting Baseline Assessment Assistance on behalf of the patient?

☐ NO, assessments completed and patient can proceed with treatment

☐ YES, assistance requested to conduct the following assessments at patient's home (check all that apply): ☐ ECG **Blood tests:** ☐ CBC with differential ☐ LFTs ☐ Ophthalmic assessment ☐ VZV serology if required

7 ECG INTERPRETATION (*REQUIRED) – COMMERCIALLY INSURED PATIENTS ONLY†

Are you requesting a cardiologist interpret the ECG on behalf of the patient?* ☐ Yes ☐ No **If "YES," fax previously completed ECG to 1-833-661-1934.**

This service is only available for an ECG previously completed within the last 6 months.

8 PRESCRIPTION INFORMATION (*REQUIRED)

Dosage & Quantity*	Refills*	Voucher Rx	Interim Care Rx	Interim Care Rx Refills
☐ VELSIPITY, 2 mg, PO, Once-daily, 30 tablets		☐	☐	

No action can be taken until the Baseline Assessment Confirmation form is received

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

Patient's current medication(s) _____

9 PRIMARY DIAGNOSIS (*REQUIRED)

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

☐ ICD 10 K51.90 (Ulcerative Colitis, unspecified, without complications) ☐ ICD 10 K51.00 (Ulcerative [chronic] Pancolitis, without complications)

☐ ICD 10 K51.80 (Other Ulcerative Colitis, without complications)

Other _____

10 HEALTHCARE PROVIDER CONSENT TO SHARE HEALTH INFORMATION AND TCPA ATTESTATION (*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 co-pay support or free drug programs, for which the patient may be eligible, and other support for the prescribed Pfizer medication(s).

I also give my permission to receive calls related to these services from Pfizer, VelsipityForMe, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

☐ Yes ☐ No

X _____ _____ _____

Prescriber Signature: NO STAMPS (Dispense as Written) **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 VelsipityForMe 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.

†*Terms and conditions apply. Not available in MA, MI, MN or RI.*

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INTERIM CARE RX PROGRAM TERMS & CONDITIONS

Interim Care Rx is not health insurance and is available for eligible, commercially insured patients who experience a delay or denial in insurance coverage during the prior authorization or appeal process or denial due to a new market block. Offer is only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY. 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. To be eligible for an additional 30-day refill, the patient must be actively pursuing coverage through their insurance awaiting a prior authorization/appeal decision or removal of a new to market block. For patients with a new to market block on the medication, VELSIPITY may be provided for 180 days. Interim Care for VELSIPITY may not exceed 2 years for any patient. 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. If you have questions or are in need of additional support, call 800-350-3080, visit www.VELSIPITY.com , or mail to VelsipityForMe at 2730 S. Edmonds Lane, Lewisville TX 75067.

VOUCHER TERMS AND 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, 30-day supply of VELSIPITY. Only new patients may use this voucher. By redeeming this voucher, you certify that you are not currently using VELSIPITY. 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).** This voucher is not valid where prohibited by law. This voucher cannot be combined with any other savings, free trial or similar offer for the specified prescription. This voucher should not be combined with samples for the specified prescription. **This free trial voucher is not health insurance.** This free trial voucher is not intended 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 VELSIPITY. Pfizer reserves the right to rescind, revoke, or amend this offer without notice. This voucher expires 12/31/2024.
**MA residents may select their pharmacy. Otherwise, this free trial will be supplied through VelsipityForMe.*

VELSIPITY AT-HOME BASELINE ASSESSMENT/PRESCREENING TESTS PROGRAM TERMS AND CONDITIONS

By agreeing to participate in the VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:

- Patients are not eligible for the VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program if they are enrolled in Medicare, Medicaid, or other federal or state healthcare programs, or if they reside in Massachusetts, Michigan, Minnesota, or Rhode Island.
- The VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program is valid only for patients with commercial (private) insurance. Baseline Assessments/Prescreening Tests include initial blood tests, ECG screening, eye exam, and baseline skin examination.
- The VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program is not health insurance.
- Patients must be enrolled in the VelsipityForMe program to participate in the VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program.
- Offer is only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY (etrasimod).
- Offer only good in the U.S. and Puerto Rico.
- No other purchase is necessary.
- The program is not valid where prohibited by law.
- Patient must be 18 years of age or older.
- Other patient support services offered through VelsipityForMe cannot begin until a signed Baseline Assessment Confirmation form is received by VelsipityForMe.
- Pfizer reserves the right to rescind, revoke, or amend the program without notice.
- If you have questions or are in need of additional support, call 800-350-3080, visit www.VELSIPITY.com, or mail to VelsipityForMe at 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067.

VELSIPITY ECG INTERPRETATION TERMS AND CONDITIONS

By agreeing to participate in the VELSIPITY ECG Interpretation Program, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:

- Patients are not eligible for the VELSIPITY ECG Interpretation Program if they are enrolled in Medicare, Medicaid, or other federal or state healthcare programs, or if they reside in Massachusetts, Michigan, Minnesota, or Rhode Island.
- The VELSIPITY ECG Interpretation Program is valid only for patients with commercial (private) insurance.
- The VELSIPITY ECG Interpretation Program is only available to patients if an ECG has been previously conducted within 6 months of the request for service.
- The VELSIPITY ECG Interpretation Program is not health insurance.
- Patients must be enrolled in the VelsipityForMe program to participate in the VELSIPITY ECG Interpretation Program.
- Offer is only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY (etrasimod).
- Offer only good in the U.S. and Puerto Rico.
- No other purchase is necessary.
- The program is not valid where prohibited by law.
- Patient must be 18 years of age or older.
- Other patient support services offered through VelsipityForMe cannot begin until a signed Baseline Assessment Confirmation form is received by VelsipityForMe.
- Pfizer reserves the right to rescind, revoke, or amend the program without notice.
- If you have questions or are in need of additional support, call 800-350-3080, visit www.VELSIPITY.com, or mail to VelsipityForMe at 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067.

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