Velsipity for me
PATIENT SUPPORT PROGRAM

VELSIPITY® (etrasimod)

# Pfizer Patient Assistance Program*

**TELEPHONE:** 1-800-350-3080 **FAX:** 1-646-862-9655 **ADDRESS:** 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

## PATIENT APPLICATION

Please complete the form where applicable and return via mail or fax. All pages must be returned to VelsipityForMe.

☐ **Check here if reapplying for the Pfizer Patient Assistance Program.**

**FOR PATIENTS – Complete the following sections; then, read, sign, and date (where applicable) the required authorization and consents on pages 1, 2, 3, and 4.**

☐ **Check here if reapplying for the Pfizer Patient Assistance Program.**

## 1 PATIENT INFORMATION (*REQUIRED)

**First Name*** _____ MI _____ **Last Name*** _____

**Date of Birth** (mm/dd/yyyy)* _____ **Gender***: ☐Male ☐Female ☐Other

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

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

Email _____ Preferred Language if not English _____

Caregiver Name _____ Phone _____ Email _____

## 2 INSURANCE INFORMATION (*REQUIRED) ☐ Check here if you are reapplying and your insurance information has not changed

**NOTE:** Patients with commercial insurance are not eligible for the Pfizer Patient Assistance Program, even if the medication is not covered by the commercial insurance plan.

**My provider or pharmacy has reviewed my insurer-required product costs with me and I certify that I am unable to afford this.*** ☐Yes ☐No

**If Yes, the four fields below are required and can be completed by either your healthcare provider, you/the patient, or both.**

Insurer required copayment (after Prior Authorization, if required) _____ Out-of-pocket (OOP) maximum for prescriptions _____

Amount met towards OOP max _____ Date Information obtained from Payer/SPP _____

**Insurance Type* (Check all that apply):** ☐**Commercial/Employer** ☐**Medicare Part D** ☐**Medicare A/B only** ☐**Medicaid** ☐**VA Benefits** ☐**Other** _____ ☐**No insurance**

| | Primary Medical Insurance* | Primary Drug Insurer* | Secondary Prescription Insurance |
|---|---|---|---|
| | (*REQUIRED only if front and back copies of insurance card[s] are NOT submitted with the completed form) | | |
| **Policy Holder Name*** | | | |
| **Insurance Name*** | | | |
| **Insurance Phone*** | | | |
| **Policy ID#*** | | | |
| **Group #*** | | | |
| **BIN #*** | | | |
| **PCN #*** | | | |

**Medicare Part D Insurance (Required for all Medicare Part D patients)**
Address City State ZIP

## 3 CERTIFICATION FOR MEDICARE PART D/MEDICARE ADVANTAGE PATIENTS ONLY (*REQUIRED)

By signing below, I certify that I:

- Have enrolled in the Medicare Prescription Payment Plan (allows patients to pay their prescription drug costs in capped monthly payments instead of all at once),
- Understand my prescription costs after my healthcare provider has obtained Prior Authorization (if required by my insurer) and that, once I meet my out-of-pocket maximum, I will have to pay $0 for covered medicines for the remainder of the year,
- Have NOT paid my $2,000 total prescription costs for the year that I am requesting assistance (my out-of-pocket maximum has not been met),
- And cannot afford my prescription cost for the Pfizer Product(s) prescribed.

SIGN X _____ _____ _____

**Patient or patient representative signature*** (must be 18 years or older)† **Patient or patient representative name** (please print)‡ **Date***

**If signed by patient representative, you must indicate below the authority to act on behalf of patient§:**

☐Court Appointed ☐Parent/Guardian ☐Power of Attorney, including authority to make healthcare decisions ☐Other _____

*The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. Free medicines from Pfizer are provided through the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation™ is a separate legal entity from Pfizer Inc. with distinct legal restrictions.
†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡NOT required if patient signs.
§Required if patient representative signs.

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## FOR PATIENTS

### 4 PATIENT FINANCIAL INFORMATION (*REQUIRED)

**To be considered for enrollment in the Pfizer Patient Assistance Program, patients must have an annual pre-tax household income at or below 300% of the Federal Poverty Level.**

**Total Number of People Within Household (including applicant)*** _____ **Total Pre-tax Annual Household Income* $** _____

**Please submit the required documentation outlined below.**

Attached is: ☐Most recent federal tax return (1040/1040-SR form)—**Required unless tax return is not filed** ☐W-2 form ☐Other _____

### 5 PFIZER PATIENT ASSISTANCE PROGRAM CERTIFICATION (*REQUIRED)

**The information you provide will be used by Pfizer Inc. ("Pfizer"), the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.**

**Patient Declaration –** By signing below, I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. **I understand that:** Completing this enrollment form does not guarantee that I will qualify for the Pfizer Patient Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by the Pfizer Patient Assistance Program shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Pfizer Patient Assistance Program, Pfizer will notify my Part D Plan of my enrollment in the Pfizer Patient Assistance Program. If I am a commercially insured patient applying after January 1, 2024, I cannot receive assistance through the Pfizer Patient Assistance Program even if my prescription is not covered by the commercial insurance plan. Any employer funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that I am a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan. **I certify and attest that if I receive medicine(s) provided by Pfizer through the Pfizer Patient Assistance Program:** I will promptly contact the Pfizer Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D true out-of-pocket costs (TrOOP) for prescription drugs. I will not submit claims, seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, including Medicare Part D plans. I will notify my insurance provider of the receipt of any medicines through the Pfizer Patient Assistance Program. I have a signed copy of a current and completed Authorization to Share Health Information form on record with my Prescriber so that my Prescriber may share health information about me with the Pfizer Patient Assistance Program, Pfizer, and the Pfizer Patient Assistance Foundation Inc.

SIGN X _____ _____ _____

**Patient or patient representative signature* (must be 18 years or older)†** **Patient or patient representative name (please print)‡** **Date***

**If signed by patient representative, you must indicate below the authority to act on behalf of patient§:**

☐Court Appointed ☐Parent/Guardian ☐Power of Attorney, including authority to make healthcare decisions ☐Other _____

### 6 PATIENT PRIVACY NOTICE AND CONSENT TO PROCESS HEALTH INFORMATION (*REQUIRED)

By checking the box below, you understand that Pfizer Inc., the Pfizer Patient Assistance Foundation, Pfizer's affiliates, and its vendors (collectively, "Pfizer") will use the health information you and your healthcare providers provide us to provide you with the Patient Support Activities. You have the right to withdraw these permissions at any time and can do so by contacting VelsipityForMe at 1-800-350-3080. You can find more information about how Pfizer Inc. handles your personal information in our Privacy Policy at pfizer.com/privacy.

I understand that I have the right to withdraw my consent by calling 1-800-350-3080, and that if I withdraw my consent it will be effective for any future disclosures but will not affect disclosures already made.

☐***I understand and consent to the terms of the Privacy Notice and Consent to Process Health Information.**

### 7 PATIENT CONSENT TO RECEIVE CALLS AND TEXTS (*REQUIRED)

By providing my mobile number and checking the box below, I or my caregiver agree to receive calls and texts from Pfizer or parties acting on its behalf, to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, refill reminders from VelsipityForMe, information and other Patient Support Activities (such as copay support or free drug programs) and for other non-marketing purposes (such as enrollment status and shipping updates) at the telephone number(s) I or my caregiver provide.

**Please enter the mobile number you would like to enroll for texting** (____) -_____

☐***I or my caregiver agree to receive calls and texts from Pfizer or parties acting on its behalf as stated.**

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†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡NOT required if patient signs.
§Required if patient representative signs.

## 8 PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (*REQUIRED)

**This must be signed and returned to VelsipityForMe to receive assistance.**

**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**.** By signing and dating 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 and date 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 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 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 will receive a copy of this form.

SIGN X _____ _____

**Patient or patient representative signature* (must be 18 years or older)†** **Date***

SIGN X _____ _____

**Patient or patient representative name (please print)‡** **Date**

**If signed by patient representative, you must indicate below the authority to act on behalf of patient§:**

☐ Court Appointed ☐ Parent/Guardian ☐ Power of Attorney, including authority to make healthcare decisions
☐ Other _____

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## HCP TO COMPLETE

Please complete the form where applicable and return via mail or fax. All pages must be returned to VelsipityForMe.

**IMPORTANT NOTE: Commercially Insured patients are not eligible for assistance. Patients must have an FDA-approved diagnosis to be considered for the Pfizer Patient Assistance Program.**

☐ **Check here if the patient is reapplying for the Pfizer Patient Assistance Program.**

**PATIENT INFORMATION** **First name*** _____ MI ____ **Last name*** _____ **Date of Birth** (mm/dd/yyyy)* _____

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

**FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page.**
**Fax COMPLETED pages 1-5 with a cover sheet to 1-646-862-9655.**

## 9 PRESCRIBER INFORMATION (*REQUIRED)

**First Name*** _____ **Last Name*** _____

**Payer Specific #*** _____ **NPI #*** _____ **State License #*** _____

**Practice Name*** _____ **Address*** _____ **City*** _____ **State*** _____ **ZIP*** _____

**Office Contact Name*** _____ **Office Contact Phone*** _____ **Office Fax*** _____

Email _____ Preferred Communication Method: ☐ Phone ☐ Fax

## 10 DIAGNOSIS (*REQUIRED) – Do not attach any clinical or office notes as this may delay processing the form

☐ **Primary ICD-10*** _____ ☐ Secondary ICD-10 _____

## 11 PRESCRIPTION INFORMATION

**Prescription for VELSIPITY** (30 Tablets) ☐ 2 mg, PO, Once-daily Refills (up to 11) _____

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

Concomitant Medications:

**Baseline Assessments completed:** ☐ Yes, and patient can proceed with therapy ☐ No

## 12 SHIPPING INFORMATION (*REQUIRED)

**Ship to***: ☐ Patient ☐ Prescriber ☐ Other (please provide shipping address—NO PHARMACIES) _____

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

SIGN X _____ _____

**Prescribing Healthcare Provider Signature* – NO STAMPS** **Date***

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☐ **Check here if the patient is reapplying for the Pfizer Patient Assistance Program.**

**PATIENT INFORMATION** **First name*** _____ MI ____ **Last name*** _____ **Date of Birth** (mm/dd/yyyy)* _____

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

**FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page.**
**Fax COMPLETED pages 1-6 with a cover sheet to 1-646-862-9655.**

**IMPORTANT NOTE: Commercially Insured patients are not eligible for assistance. Patients must have an FDA-approved diagnosis to be considered for the Pfizer Patient Assistance Program.**

## 13 PRIOR AUTHORIZATION AND INSURER REQUIRED COSTS (*REQUIRED)

**The product costs were obtained from the payer/pharmacy and my patient has certified that they are unable to afford this.***: ☐ Yes ☐ No

**If Yes, the four fields below are required and can be completed by either you the healthcare provider, the patient, or both.**

**Insurer required copayment (after Prior Authorization, if required)*** _____ **Out-of-pocket (OOP) maximum for prescriptions*** _____

**Amount met towards OOP max*** _____ **Date Information obtained from Payer/SPP*** _____

**Does the payer require a Prior Authorization?***: ☐ Yes ☐ No **Prior Authorization Number†*** _____ **Prior Authorization Dates†*** _____

## 14 PRESCRIBER CERTIFICATION (*REQUIRED)

**The information you provide will be used by Pfizer Inc. ("Pfizer") to improve and tailor our products and services to better serve you. The information will also be used by the Pfizer Patient Assistance Foundation™ and parties acting on their behalf to administer and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.**

**By signing below, you, the Prescriber, understand and agree to the following:** I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable. Any medications supplied by Pfizer as a result of this enrollment form are for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement, nor will any cost related to it be applied toward the patient's true out-of-pocket costs (TrOOP). I certify that the information provided is current, complete, and accurate to the best of my knowledge. **I certify that my decision to prescribe a Pfizer product is based solely on my independent clinical judgment and I have prescribed the product for an FDA-approved indication.** I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. I understand that commercially insured patients are not eligible for the Pfizer Patient Assistance Program, even if their prescription is not covered by the commercial insurance plan. Any employer funded and/or commercial insurance plan requiring patients to apply to the Pfizer Patient Assistance Program as a prerequisite to or requirement for coverage of a Pfizer product, commonly known as alternate funding programs (also referred to as specialty networks and specialty carve-outs) are not eligible for the Pfizer Patient Assistance Program. The Pfizer Patient Assistance Program is for the benefit of the patient only. I agree to inform Pfizer if I become aware that the patient is a member of such an insurance plan, or if I am applying to the Pfizer Patient Assistance Program on behalf of a member who is enrolled in such an insurance plan. If the patient has Medicare Part D, Pfizer will notify the Medicare Part D plan of their participation in the Pfizer Patient Assistance Program. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. Pfizer may contact the patient directly to confirm the receipt of medications. The information provided on this enrollment form is subject to random audits and verification. Pfizer may change or cancel this program at any time; Pfizer also reserves the right to terminate my patient's enrollment at any time. I will notify the Pfizer Patient Assistance Program immediately if the Pfizer product is no longer medically necessary for this patient's treatment or if my patient's insurance or financial status changes. I have a signed copy on file of my patient's current and completed Patient Authorization to Share Health Information Form so that I may share patient health information with the Pfizer Patient Assistance Program, Pfizer, and the Pfizer Patient Assistance Foundation Inc.

SIGN X _____ _____

**Prescribing Healthcare Provider Signature*** **Date***

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†Required if a Prior Authorization is required by the payer.

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.