Velsipityforme

PATIENT SUPPORT PROGRAM

VELSIPITY™ (etrasimod)

Voucher for a one-time, 30-day trial supply of VELSIPITY™ (etrasimod)

TO ORDER A ONE-TIME, 30-DAY TRIAL SUPPLY FOR PATIENTS NEW TO VELSIPITY:

COMPLETE FORM TO THE RIGHT

Complete the information to the right and fax the completed voucher to VelsipityForMe at 1-646-862-9655.
If you are a New York prescriber, please attach state prescription form.

— OR —

E-PRESCRIBE DIRECTLY TO SONEXUS HEALTH PHARMACY SERVICES

2730 S. Edmonds Lane #400, Lewisville, TX 75067 (NCPDP: 5910206; NPI: 1447680210).

If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying you have received patient consent for Sonexus Health Pharmacy Services and VelsipityForMe to contact your patient or caregiver and provide them services.

Inform the patient or caregiver to expect a call to schedule delivery for a one-time, 30-day trial supply of VELSIPITY.

Massachusetts residents may select their pharmacy. Otherwise, this free trial will be supplied through VelsipityForMe. Vouchers and samples cannot be combined to support one single patient and are not intended to address financial hardship and insurance delays. See terms and conditions on the right.

QUESTIONS? Call VelsipityForMe at
1-800-350-3080

PATIENT INFORMATION:

FIRST NAME _____ LAST NAME _____

DOB (mm/dd/yyyy) _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PREFERRED PHARMACY (Massachusetts residents only) _____

HEALTHCARE PROVIDER INFORMATION:

PRESCRIBER NAME (First, Middle Initial, Last) _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

NPI # _____ Fax _____ Office Contact Name _____

PRESCRIPTION INFORMATION:

PATIENT NAME (First, Middle Initial, Last) _____ PATIENT DOB (mm/dd/yyyy) _____

Primary ICD-10 Diagnosis Code: _____

VELSIPITY, 2 mg, PO, Once-daily, 30 tablets

Baseline Assessment completed: ☐ Yes ☐ No

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

I authorize VelsipityForMe to forward the prescription to a pharmacy for fulfillment.

X _____

Prescriber Signature _____ Date _____

VOUCHER TERMS AND CONDITIONS FOR THE PATIENT

By redeeming this voucher, you acknowledge that you currently meet the eligibility criteria and will comply with the terms & conditions described below:

Only new patients may use this voucher and each patient is limited to one voucher. By redeeming this voucher, you certify that you are not currently using VELSIPITY.

- This voucher may not be transferred, sold, purchased, traded, or counterfeited.
- 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).**
- You must be 18 years of age or older to redeem this voucher.
- This voucher is not valid for Massachusetts residents whose prescriptions are covered in whole or in part by third party insurance.
- This voucher is not valid where prohibited by law.
- This voucher cannot be combined with any other external 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 may not be used 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.

Pfizer