Velsipityforme
PATIENT SUPPORT PROGRAM

Program Enrollment Form

For assistance, CALL 1-800-350-3080, 8 AM–8 PM ET, M–F

Fax COMPLETED pages 1–3 with a cover sheet to 1-646-862-9655.

1 PATIENT INFORMATION (*= required field) *Complete all required fields*

First Name* _____ MI _____ **Last Name*** _____ **DOB (mm/dd/yyyy)*** _____

Sex* ☐Male ☐Female (Sex describes one's biology at birth)

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

Phone*: Mobile _____ **Home** _____ **Permission to leave a Voicemail***: ☐Y ☐N

Best Time to Contact: ☐AM ☐PM Preferred Language (if not English): _____

Email (Required to access VelsipityForMe Patient Portal)* _____

Legally Authorized Representative: Name _____ Phone _____ Email _____

2 PATIENT INSURANCE INFORMATION (*= required field) *To accompany submission of Program Enrollment Form*

Patient Demographics Sheet or Front and Back Copies of Prescription and Medical Insurance Cards*

Please ensure the Patient Demographic Sheet includes the following patient information: full home address, email address, medical and prescription insurance information. Please redact the patient's SSN from the sheet. Failure to include the demographic sheet may result in delayed enrollment.

Preferred Specialty Pharmacy: _____

☐ This prescription has also been sent to a Specialty Pharmacy Provider (SPP). SPP Name _____ SPP Phone Number _____

3 PRESCRIBER INFORMATION (*= required field)

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

NPI #* _____ **State License #** _____ **Practice Name*** _____

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

Office Contact Name* _____ **Office Contact Phone*** _____ Ext. _____

Email _____ **Office Fax*** _____ Best Time to Contact: ☐AM ☐PM

Preferred Communication: ☐Phone ☐Fax ☐Email

4 ASSESSMENTS† (*= required field) *For eligible, COMMERCIALLY INSURED patients ONLY*

4A PRE-INITIATION ASSESSMENTS*

☐ Patient **CLEARED** for therapy (Completed ECG and Blood Tests)

Patient **NOT** cleared for therapy. Support requested for:

☐ ECG OR ☐ ECG Interpretation (fax ECG to 1-833-661-1934)

Blood Tests: ☐ CBC ☐ LFTs ☐ VZV serology

4B BASELINE ASSESSMENTS See full Terms and Conditions on page 3

Support requested for:

☐ Eye Exam

☐ Skin Exam (This service is to facilitate scheduling only.)

†In-home or in-office based on patient's preference

GOVERNMENT OR UNINSURED PATIENTS SELECT ONE* ☐Patient is **CLEARED** for therapy ☐ Patient is **NOT** cleared for therapy

5 PRESCRIPTION INFORMATION (*= required field)

Interim Care (Bridge) Rx is for commercially insured patients only, and is only filled through Sonexus Health Pharmacy Services. By requesting this, you certify you understand the terms and conditions on page 3, and agree to complete appeals when required. See full Terms and Conditions on page 3.

☐ Prescription for VELSIPITY, 2 mg, PO, Once-daily, 30 tablets* Refills (up to 11 refills/yr) _____ if applicable for Specialty Pharmacy triage

☐ Interim Care (Bridge) Rx for VELSIPITY, 2 mg, PO, Once-daily, 30 tablets (up to 11 refills/yr)

☐ Voucher Rx for VELSIPITY, 2 mg, PO, Once-daily, 30 tablets (One-time 30-day supply)‡

Pre-Initiation Assessment Confirmation Form is required prior to dispensing medication.

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

6 PRIMARY DIAGNOSIS (SELECT ONE REQUIRED)* *Please check or complete appropriate patient diagnosis.*

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

☐ Ulcerative Colitis K51.00 ☐ Ulcerative Colitis K51. _____ (please add remaining numbers to complete this ICD-10 code) ☐ Other _____

7 HEALTHCARE PROVIDER CERTIFICATION (*= required field)

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.

PRESCRIBER SIGNATURE X _____ _____

Prescriber Signature*: NO STAMPS (Dispense as Written) **Date*** **Prescriber Signature*: NO STAMPS (Substitution Allowed)** **Date***

_____

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 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.

‡*The voucher prescription is a limited trial supply to evaluate the safety and efficacy of the medication.*

Phone 1-800-350-3080 | Monday–Friday, 8 AM–8 PM ET **Fax 1-646-862-9655**
2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067

FOR PATIENTS

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION (*= required field)

I authorize (i.e., allow) the use and/or disclosure of information about me, including information related to my medical condition, diagnosis, and treatment; prescription medications; health insurance coverage and claims; and my contact information ("Health Information"), to be shared with Pfizer, the Pfizer Foundation, and their respective partners, affiliates, subcontractors, and agents (together "Pfizer"). This information may also be considered sensitive data under state law in some jurisdictions. I understand that this authorization is voluntary.

1. **Person(s) or Class of Person(s) Authorized to Disclose Health Information:** My health care providers, including my treating physicians and medical or diagnostic laboratories and pharmacies, that provide health care to me and conduct medical testing.
2. **Purpose(s) for the Use and/or Disclosure of Health Information:** For Pfizer and the Pfizer Patient Support Program to provide and administer Pfizer's patient support services. Depending on the program, this may include for example collecting, using, and disclosing health information:
   - Enrollment in the Program.
   - Disease and treatment education.
   - To conduct benefits verification, support prior authorization, and appeals processes.
   - Assessment for copay and affordability programs and determining eligibility for and enrolling me in patient financial assistance programs.
   - Pharmacy coordination, prescription triage and dispensing support, refill and titration reminders, adherence support.
   - Disease information and marketing material about other Pfizer products, services, and programs, if I have elected to receive those communications below.
   - Internal Program business purposes, such as analytics and service improvement.
   - Personalized marketing content across various media channels regarding products, treatments, and offers, if I have elected to receive those communications below.
   - Patient support-related communications delivered via telephone, email, or mail, including through automated and prerecorded/AI technology, using the information collected in connection with this form, for non-marketing purposes.
3. **No Conditioning.** I understand that my treatment, enrollment, eligibility, and payment under my health plan are not conditioned upon me signing this form and agreeing to permit the disclosure of my Health Information to Pfizer and its authorized service providers.
4. **Right to Revoke.** I may revoke (i.e., take back) this authorization at any time, except to the extent that my health care providers or other recipients have taken any action in reliance on my authorization. I understand that if I revoke this authorization, it will not have any effect on any uses or disclosures of my Health Information that occurred prior to receiving my revocation. To revoke, I understand that I must notify Pfizer by emailing No-Reply_VelsipityForMe_Consent@pfizer.com, or by calling 1-800-350-3080, 8 AM–8 PM ET, M–F.
5. **Remuneration.** My specialty pharmacies may receive compensation from Pfizer in connection with patient support, including my Protected Health Information (PHI) as described in this authorization.
6. **Expiration of Authorization.** This authorization will remain in full force and effect for two years from the date of this authorization, unless I revoke it prior to this time or my state requires a shorter period.
7. **Potential for Re-disclosure.** My Health Information released under this authorization may not be protected under federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Pfizer will only use and share my Health Information for purposes stated on this authorization or as otherwise permitted by law.
8. **Copy of Authorization.** I understand that I am entitled to receive a signed copy of this authorization.

I have read this authorization and/or had its contents read to me. I authorize the use and disclosure of my Health Information as described in 1–8 above.

PATIENT SIGNATURE X _____ _____ _____

Patient or Legally Authorized Representative signature* **(must be 18 years or older)†** | **Print patient or Legally Authorized Representative name*** | **Date***

Patient Date of Birth* _____

If signed by Legally Authorized 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 _____

†Patients who are 18 years or older must sign unless incapacitated; otherwise, a Legally Authorized Representative can sign on their behalf.
‡Required if Legally Authorized Representative signs.

Phone 1-800-350-3080 | Monday–Friday, 8 AM–8 PM ET **Fax 1-646-862-9655**
2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067

8 COMMUNICATIONS REGARDING ADDITIONAL OPPORTUNITIES (Optional)

☐ By checking this box, you consent to Pfizer and Pfizer's partners using the information collected in connection with this form, and other information we may have about you, to provide you with personalized communications across various media channels regarding products, treatments, programs, services, scientific research and other research opportunities. Communications may include marketing texts, emails, or calls to the phone number you provided in connection with this form, including through automated and prerecorded/AI technology. Consent is not required or a condition of any service. For texts, message frequency varies, message and data rates may apply, and complete texting terms can be found at velsipityforme.pfizer.com/sms-terms. Text STOP to opt out of text messages.

Certain information, such as details about your health information and related inferences, may be considered sensitive under applicable law. Pfizer values your privacy and will handle all personal information in accordance with our Privacy Policy and Washington Health Data Privacy Policy. You can withdraw your permission at any time by following the unsubscribe instructions in the communications you receive.

9 TERMS & CONDITIONS

INTERIM CARE RX PROGRAM TERMS & CONDITIONS

Interim Care 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 VELSIPITY® (etrasimod). The Interim Care Program is applicable to all VELSIPITY® formulations. 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 or Michigan. For residents of Minnesota or Rhode Island, available for up to six months. For all other eligible patients, this program is available for a period of up to two years (lifetime maximum) or until they receive insurance coverage approval, whichever occurs earlier. Available in 30-day supply. Refills are subject to limitations. Continued eligibility for the program requires, 1. submission of first appeal within 60 days of enrollment (or within the required payer timeline, if sooner) in the Interim Care Program and submission of the second appeal, if allowed by the payer, within 60 days of the date of the first appeal denial (or within the required payer timeline, if sooner), 2. satisfying all payer appeal requirements and 3. patients schedule their initial prescription dispense within 60 days of enrollment. If at any time during the patient's Interim Care Program enrollment there is a payer coverage change relating to the applicable product, Pfizer may conduct a new benefits investigation, and, if allowed by the payer, submission of a new Prior Authorization request and an appeal, if denied, must be submitted within 60 days (or within the required payer timeline, if sooner) of either, 1. the date of completion of the benefits investigation, provided by the VelsipityForMe Program to the patient's authorized healthcare provider, or 2. the date a new submission is allowed by the payer, for continued eligibility in the program, whichever is later. If there is no payer coverage change, at 12 months of Interim Care Program enrollment, an updated prescription and benefits investigation is required to confirm continued eligibility. Interim Care 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 can only be dispensed by the exclusive pharmacy and only after a benefits investigation has been completed and a delay occurs in the Prior Authorization process, or an appeal is required. All payer appeal timelines must be met for continued assistance. 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. Additional eligibility criteria may apply. Contact VelsipityForMe at 1-800-350-3080 for details.

VOUCHER TERMS AND CONDITIONS

- You will receive a one-time 30-day supply of VELSIPITY.
- 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 12/31/2027.

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

By agreeing to participate in the VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program or the In-Office Scheduling 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 and/or In-Office Scheduling Program if they are enrolled in Medicare, Medicaid, or other federal or state healthcare programs, or if they reside in Michigan, Minnesota, or Rhode Island.
- The VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program and In-Office Scheduling Program are valid only for patients with commercial (private) insurance.
- The VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program include initial blood test, ECG screening, and eye exam.
- The In-Office Scheduling Program includes scheduling for skin testing and an eye exam only based upon certain identified demographic criteria.
- The VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program and In-Office Scheduling Program are not health insurance.
- Patients must be enrolled in the VelsipityForMe program to participate in the VELSIPITY At-Home Baseline Assessment/Prescreening Tests Program and/or the In-Office Scheduling Program.
- Offers are only available to patients who have been diagnosed with an FDA-approved indication for VELSIPITY (etrasimod).
- Offers only good in the U.S. and Puerto Rico.
- No other purchase is necessary.
- The programs are not valid where prohibited by law.
- Patient must be 18 years of age or older.
- If requesting either an ECG and or initial blood test through the At-Home Baseline Assessment/Prescreening Tests Program, other 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 programs without notice.
- If you have questions or are in need of additional support, call 1-800-350-3080, 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 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 1-800-350-3080, visit www.VELSIPITY.com, or mail to VelsipityForMe at 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067.

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit ***pfizer.com/privacy***.