Velsipityforme

PATIENT SUPPORT PROGRAM

VELSIPITY® (etrasimod)

VELSIPITY® (etrasimod) Extended Care Cash Pay Discount Program Prescription Form

This form is only for eligible, commercially insured residents of Massachusetts, Michigan, Minnesota, and Rhode Island, or Interim Care patients exhausting the 2-year interim care lifetime maximum with no change in insurance coverage for Velsipity.*

The VELSIPITY Extended Care Cash Pay Discount Program:

- Expands the opportunity for eligible patients to start or continue to receive VELSIPITY.
- Available to eligible, commercially insured patients enrolled in the VelsipityForMe program.
- Patients pay $5 per dispense. Terms and conditions apply. See terms and conditions below.

Eligible Patients Include:

1. Commercially insured residents of Massachusetts (MA) and Michigan (MI).
2. Commercially insured residents of Minnesota (MN) and Rhode Island (RI) exhausting the 6-month interim care eligibility with no change in insurance coverage for VELSIPITY.
3. Interim care patients exhausting the 2-year interim care lifetime maximum with no change in insurance coverage for VELSIPITY.

TO ENROLL ELIGIBLE PATIENTS INTO THE PROGRAM

COMPLETE FORM TO THE RIGHT

Complete the information to the right and **fax the completed form to VelsipityForMe at 1-646-862-9655** or contact your Pfizer Dedicated Care Coordinator at 1-800-350-3080.

— 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.

*Residents of Minnesota (MN) and Rhode Island (RI) exhausting the 6-month interim care eligibility with no change in insurance coverage for VELSIPITY.

PATIENT INFORMATION

FIRST NAME _____ LAST NAME _____

DOB (mm/dd/yyyy) _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

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) _____

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

Extended Care Cash Pay Discount Rx Refills (Up to 11) _____

Pre-Initiation Assessment completed: ☐ Yes ☐ No

No action can be taken until the Pre-Initiation Assessment Confirmation form is received.

X _____

Prescriber Signature _____ Date _____

VELSIPITY® (etrasimod) Extended Care Cash Pay Discount Program Terms & Conditions

By agreeing to participate in the VELSIPITY® Extended Care Cash Pay Discount Program (this "Program"), you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:

- Individuals are not eligible for this Program if they are enrolled in any federal healthcare program (as defined in 42 U.S.C. § 1320a-7b(f)), including Medicare, Medicaid, TRICARE, any state prescription drug assistance program, and the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud")
- Individuals must be:
  - a resident of Michigan (MI) and Massachusetts (MA)
  - a resident of Minnesota (MN) and Rhode Island (RI) who is or was enrolled in the VELSIPITY Interim Care Program (the "ICP") and will be exhausting the ICP benefits (1) with no change in insurance coverage for VELSIPITY®, or (2) was denied insurance coverage for VELSIPITY®
  - enrolled in the ICP and have exhausted the two (2)-year interim care lifetime maximum with no change in insurance coverage for VELSIPITY® or received a final determination from their insurance company denying coverage for VELSIPITY®
- Individuals must have a valid prescription for VELSIPITY® and be enrolled in the VelsipityForMe patient support program

Offer is not health insurance and is only available to patients diagnosed with an FDA-approved indication for VELSIPITY®. This VELSIPITY® Extended Care Cash Pay Discount Program is applicable to all VELSIPITY® formulations. No claim for reimbursement for any product dispensed pursuant to this Program may be submitted to any third-party payer. Product is available in 30-day supply only. Refills are subject to limitations. For enrollment into the Program and continued eligibility, you must be experiencing a delay in, or have been denied, coverage for VELSIPITY® by your commercial insurance plan. To confirm continued eligibility, a periodic benefits investigation will be conducted, and an updated prescription is required annually. If, at any time during the patient's VELSIPITY® Extended Care Cash Pay Discount Program enrollment, there is a change in the patient's insurance coverage for VELSIPITY®, Pfizer may terminate the patient's enrollment in the Program. Pfizer reserves the right to modify, rescind, or discontinue this Program at any time for any reason and without notification. The VELSIPITY® Extended Care Cash Pay Discount Program product will only be dispensed by the designated pharmacy. Eligible patients may receive a maximum of up to 11 prescription refills per calendar year or enrollment in the Program for 18 months in total, which is the lifetime maximum per patient. Eligible patients shall pay $5 per 30-day supply. Offer is valid only in the U.S. and Puerto Rico. This program cannot be combined with any other savings, free trial, or similar offer for the specified prescription. No other purchase is necessary. Prescription must be provided by a healthcare provider licensed in the U.S. or Puerto Rico. Program is not available where prohibited by law. Data related to your redemption of the offer may be collected, analyzed, and shared with Pfizer, for market research and other purposes related to assessing Pfizer's programs. Additional eligibility criteria may apply. Contact VelsipityForMe at 1-800-350-3080 for details.