Velsipity for me
PATIENT SUPPORT PROGRAM

Patient Authorization to Share Health Information

First Name ______________________ Last Name ______________________

Address ____

City ______________________________ State ___ ZIP Code __________

Date of Birth ________ Email ________________ Preferred Contact Phone ________________

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 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 my 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 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. I may withdraw my 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 (Patient or Patient Representative must be 18 or older) Patient Representative Name (Please Print) 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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