Velsipity for me
PATIENT SUPPORT PROGRAM

Velsipity® (etrasimod) 2mg tablets

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.

FOR PATIENTS – Complete the following sections, then read, sign, and date (where applicable) the required authorization consents on pages 2 and 3. Missing information or consents may cause delays in filling your prescription and signing you up for the VelsipityForMe Program.

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*** _____
Primary Phone* _____ Mobile Phone _____ **Permission to leave a Voicemail***: ☐Y ☐N
Best Time to Contact: ☐AM ☐PM Preferred Language (if not English): _____ **Preferred Communication***: ☐Phone ☐Email
Email (Required to access VelsipityForMe Patient Portal)* _____
Patient Representative: Name _____ Phone _____ Email _____

2 INSURANCE INFORMATION (* = required field only if copies of insurance card[s] front and back are NOT provided)

☐See attached copy of my insurance card(s), front and back, for the information requested below.

	Primary Prescription Insurance	Secondary Prescription Insurance	Primary Medical Insurance
Insurance Name*			
Insurance Phone*			
Policy ID #*			
Group #*			
Policyholder Name*			
BIN #			
PCN #			

FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page.

☐ 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: ☐Portal Notifications ☐Phone ☐Fax ☐Email Preferred Language ☐English ☐Spanish

4 BASELINE ASSESSMENTS† (*= required field) ***For commercially insured eligible patients***. *See Terms and Conditions on pg. 4*

Baseline Assessment Assistance Request on Behalf of the Patient:

Assessment assistance requested:	**Starting therapy:***
Conduct assessments at patient's home (check all that apply) ☐ECG ☐Ophthalmic Exam Blood tests: ☐CBC ☐LFTs ☐VZV serology **Schedule assessments in a provider's office** (check all that apply) ☐Skin Exam ☐Ophthalmic Exam *These services are to facilitate scheduling only.* **Interpret an ECG assessment that was already completed** ☐Cardiologist interpretation of an ECG. **Fax ECG to 1-833-661-1934.** *This service is only available for an ECG previously completed within the last 6 months.*	☐Patient **CAN proceed with treatment.** ☐Patient is **NOT yet cleared for therapy.**

5 PRESCRIPTION INFORMATION (*= required field) *Interim Care Rx is for commercially insured patients, and is only filled through Sonexus Health Pharmacy Services. By requesting this, you certify you understand the terms and conditions on page 4. See full Interim Care Rx and Voucher Rx Terms and Conditions on page 4.*

Dosage & Quantity	Rx Refills*	Voucher Rx†	Interim Care Rx‡ *Up to 2 years*	Interim Care Rx Refills *Up to 11*
☐ VELSIPITY, 2 mg, PO, Once-daily, 30 tablets*		☐	☐	

Baseline Assessment Confirmation Form is required prior to dispensing medication if ECG and/or blood testing support is requested or if assessments are being completed independently.

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

6 PRIMARY DIAGNOSIS (REQUIRED) *Complete the ICD-10 code for the patient's diagnosis.*

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

Ulcerative Colitis K51. _____ ☐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.

X _____ _____ _____

Prescriber Signature*: NO STAMPS **Print Name of Healthcare Provider* (Required)** **Date***

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.

†*Terms and conditions apply. See page 4 for terms and conditions.*
‡*The voucher prescription is a limited trial supply to evaluate the safety and efficacy of the medication.*

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***.

FOR PATIENTS

8 HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (*= required field)

I authorize (i.e., allow) the use and/or disclosure of my Protected Health Information, described below, which is protected under a federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). In general, Protected Health Information is information, including demographic information, which (1) relates to my past, present, or future physical or mental health or condition, the provision of health care to me, or the past, present, or future payment for the provision of health care to me, and (2) that identifies me or for which there is a reasonable basis to believe can be used to identify me. I understand that this authorization is voluntary.

1. **Person(s) or Class of Person(s) Authorized to Disclose Protected Health Information:** My health care providers, including my treating physicians and medical laboratories, that provide health care to me and conduct medical testing.
2. **Person(s) or Class of Person(s) Authorized to Receive Protected Health Information:** Pfizer Inc. ("Pfizer"), VelsipityForMe (the "Program"), and other authorized service providers of Pfizer.
3. **Description of Protected Health Information that may be Used and/or Disclosed:** My name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that I am seeking health care services, and data otherwise related to my health condition, diagnosis, and/or treatment.
4. **Purpose(s) for the Use and/or Disclosure of Protected Health Information:** To determine whether conditions for eligibility under the Program have been met; and to provide me with various support to help me access a Pfizer medicine, which may include the following:
   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 copay 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
   - Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services
5. **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 Protected Health Information to Pfizer and its authorized service providers.
6. **Right to Revoke.** I may revoke (i.e., take back) this authorization at any time, except to the extent that my health care providers 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 Protected Health Information that occurred prior to receiving my revocation. To revoke, I understand that I must notify VelsipityForMe by emailing No-Reply_VelsipityForMe_Consent@pfizer.com, or by calling 1-800-350-3080, 8 AM–8 PM ET, M–F.
7. **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.
8. **Potential for Re-disclosure.** Persons or entities that receive my Protected Health Information under this authorization may not be required by privacy laws (such as HIPAA) to protect the information and they may share it with others without my permission, if permitted by laws that are applicable to them.
9. **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 Protected Health Information as described in 1–9 above.

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 _____

†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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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

9 CONSENT TO COLLECT AND USE PERSONAL DATA (*= required field)

Pfizer Inc. ("Pfizer") collects certain Personal Data (described below) about individuals so that it may provide patient support services to eligible patients through the VelsipityForMe Program (the "Program"). Pfizer is seeking this consent because it needs to collect and use such data, which is considered sensitive data in some jurisdictions, in connection with operation of the Program.

Personal Data Collected and/or Used. The Personal Data Pfizer and its service providers may collect and use includes name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that you are seeking health care services, and data otherwise related to your health condition, diagnosis, and/or treatment (collectively "Personal Data").

Purposes of Collection and Use. Your Personal Data will be used for the following purposes:

Your Personal Data will be used by Pfizer who will provide patient support services to eligible patients including, where applicable, determining eligibility for copay support and free drug programs.

Duration. By signing this consent to collect and use, I agree that these entities may use the Personal Data to provide applicable patient support services or as permitted or required by applicable privacy laws. I permit such use for two years after the date I sign the consent, unless and until I revoke (i.e., take back) it in writing prior to that time.

Revocation. I may revoke my consent at any time, except to the extent that Pfizer has taken any action in reliance on my consent. I understand that if I revoke my consent, it will not have any effect on any collection, uses, or disclosures of my Personal Data that occurred prior to receiving my revocation. To revoke, I understand that I must notify VelsipityForMe by emailing No-Reply_VelsipityForMe_Consent@pfizer.com, or by calling 1-800-350-3080, 8 AM–8 PM ET, M–F.

I understand that my consent to collect and use my Personal Data is voluntary and may be revoked in writing at any time.

I have read this consent and/or had its contents read to me. I fully understand the terms and conditions described above.

Consent to Collect Personal Data:

By signing and dating below, I consent on my own free will and I agree to the collection and use of my Personal Data as described above. I understand that a signed copy of this consent is available to me upon request.

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 _____

10 CONSENT TO RECEIVE TEXT MESSAGES

By providing your phone number (_____) _____-_____, you consent to receive communications from Pfizer with information regarding the VelsipityForMe program. You understand that providing this consent is not required or a condition of purchasing any products or services. Message frequency varies. Message and data rates may apply. Complete terms can be found at velsipityforme.pfizer.com/sms-terms and Pfizer's privacy policy at pfizer.com/privacy. Text STOP to opt out of text messages.

†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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Clear Form Print Form

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

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 12/31/2025.

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 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 800-350-3080, visit www.VELSIPITY.com, or mail to VelsipityForMe at 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067.

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