Pfizer IGuide™ Co-Pay Claim Form

For CUTAQUIG® (Immune Globulin Subcutaneous [Human] – hipp) 16.5% solution, PANZYGA® (Immune Globulin Intravenous [Human] – ifas 10% Liquid Preparation, OCTAGAM® (Immune Globulin Intravenous [Human]) 10% Liquid Preparation, and OCTAGAM® (Immune Globulin Intravenous [Human]) 5% Liquid Preparation

Eligibility

Patients may be eligible for this offer if they:

- **Have commercial insurance that covers:**
  - **CUTAQUIG**
  - **PANZYGA**
  - **OCTAGAM**
- **Are not enrolled in a state- or federally-funded health insurance program**
- **Meet and agree to all terms and conditions below**

Claims Process

NOTE: Patients must be enrolled in a Pfizer IGuide™ co-pay program.

Please submit the following:

1. A completed claim form within 180 days of the issue date shown on the patient's Explanation of Benefits (EOB)
2. A copy of the EOB (or dated pharmacy receipt if the prescription was filled by a pharmacy)
3. The group and member ID information on the identification card (provided on the approval letter)

Contact Us

Please fax the completed form to 1-877-847-3291, or mail to:
Attn: Pfizer IGuide
PO Box 6875, Bridgewater, New Jersey 08807

CUTAQUIG, PANZYGA, and OCTAGAM Pfizer IGuide™ Access Counselors are available Monday through Friday, 8 AM to 8 PM ET, at 1-844-448-4337.

If there are any changes to the patient's provider, administering provider, insurance, or contact information, call the program that supports your product prior to the submission of the co-pay claim form.

Terms and Conditions: **Terms and Conditions: By using the Cutaquig Co-Pay Program, the Octagam Co-Pay Program, or the Panzyga Co-Pay Program, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:**

Patients are not eligible to use the Cutaquig Co-Pay Program card, the Octagam Co-Pay Program card, or the Panzyga Co-Pay Program card if they are enrolled in a state or federally funded insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud"). Patient must have private insurance. Offer is not valid for cash-paying patients. The value of this co-pay card is limited to a maximum of $12,500 for Cutaquig, $12,500 for Octagam, and $12,500 for Panzyga per calendar year or the cost of patient co-pay in a 12-month period, whichever is less. This co-pay card is not valid when the entire cost of your prescription drug is eligible to be reimbursed by your private insurance plan or other private health or pharmacy benefit programs. You must deduct the value of this co-pay card from any reimbursement request submitted to your private insurance plan, either directly by you or on your behalf. You are responsible for reporting use of the co-pay card to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the co-pay card, as may be required. You should not use the co-pay card if your insurer or health plan prohibits use of manufacturer co-pay cards. You must be 2 years of age or older to redeem the Cutaquig Co-Pay Program Card, Octagam 5% Co-Pay Card, or Panzyga Co-Pay Program Card. You must be 18 years of age or older to redeem the Octagam 10% Co-Pay Program Card. This co-pay card is not valid where prohibited by law. The benefit under the co-pay card program is offered to, and intended for the sole benefit of, eligible patients and may not be transferred to or utilized for the benefit of third parties, including, without limitation, third party payers, pharmacy benefit managers, or the agents of either. Co-pay card cannot be combined with any other external savings, free trial or similar offer for the specified prescription (including any program offered by a third party payer or pharmacy benefit manager, or an agent of either, that adjusts patient cost-sharing obligations, through arrangements that may be referred to as "accumulator" or "maximizer" programs). Third party payers, pharmacy benefit managers, or the agents of either, are prohibited from assisting patients with enrolling in the co-pay card program. **The Cutaquig Co-Pay Program Card, the Octagam Co-Pay Card, and the Panzyga Co-Pay Program Card will be accepted only at participating pharmacies. If your pharmacy does not participate, you may be able to submit a request for a rebate in connection with this offer. This co-pay card is not health insurance.** Offer good only in the U.S. and Puerto Rico. The Cutaquig Co-Pay Program Card, Octagam Co-Pay Program Card, and Panzyga Co-Pay Program Card are limited to 1 per person during this offering period and is not transferable. Co-pay card may not be redeemed more than once per 5 days per patient for Cutaquig, more than once per 30 days per patient for Octagam, or more than once per 13 days per patient for Panzyga. Co-pay card is limited to reimbursement of Pfizer-labeled Cutaquig (Immune Globulin Subcutaneous (Human) - hipp) only. No other purchase is necessary. No membership fee. Data related to your redemption of the co-pay card may be collected, analyzed, and shared with Pfizer, for market research and other purposes related to assessing Pfizer's programs. Data shared with Pfizer will be aggregated and de-identified; it will be combined with data related to other co-pay card redemptions and will not identify you. Pfizer reserves the right to rescind, revoke or amend this offer without notice. Offer expires 12/31/2024.

For more information about the Cutaquig Co-Pay Program, Octagam Co-Pay Program, or Panzyga Co-Pay Program call 1-866-293-5922. For more information about the Cutaquig Co-Pay Program visit https://www.cutaquiginfo.com/copay.html or write: Cutaquig Co-Pay Program, PO Box 6875, Bridgewater, NJ 08807. For more information about the Octagam Co-Pay Program, visit [Octagam5CoPay.com and Octagam10CoPay.com] or write: Octagam Co-Pay Program, P.O. Box 6875, Bridgewater, NJ 08807. For more information about the Panzyga Co-Pay Program, visit https://panzyga.pfizerpro.com/support/co-pay-program-for-patients or write: Panzyga Co-Pay Program, PO Box 6875, Bridgewater, NJ 08807.

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All fields marked with an asterisk (*) are required.

*Select product
☐ CUTAQUIG ☐ PANZYGA ☐ OCTAGAM

*Person completing form:
☐ Patient ☐ Healthcare provider ☐ Specialty pharmacy

ADMINISTERING PROVIDER *(Enter the name of the administering provider or infusion center)*

PRACTICE NAME

*PROVIDER FIRST NAME

*PROVIDER LAST NAME

PATIENT

*PATIENT FIRST NAME

*PATIENT LAST NAME

PATIENT M.I.

*SEX ☐ Male ☐ Female

*ZIP CODE

*DATE OF BIRTH

*PATIENT GROUP NUMBER
(eg, EX00000000) *(from program ID card on the approval letter)*

*PATIENT MEMBER ID NUMBER
(11-digit ID from program ID card on the approval letter)

*HCPCS CODE BILLED FOR PRODUCT
(If submitted by provider)

*DATE OF SERVICE
(Provide dose or dose range)

*PATIENT OUT-OF-POCKET AMOUNT FOR PRODUCT

UPDATED INSURANCE DETAIL *(If the insurance has changed since last submission)*

PRIMARY INSURANCE NAME

PRIMARY INSURANCE GROUP # FOR MEDICAL BENEFIT

PRIMARY INSURANCE ID FOR MEDICAL BENEFIT

PRIMARY INSURANCE BIN FOR PHARMACY BENEFIT

PRIMARY INSURANCE PCN FOR PHARMACY BENEFIT

PRIMARY INSURANCE GROUP # FOR PHARMACY BENEFIT

PRIMARY INSURANCE ID FOR PHARMACY BENEFIT

CO-PAY CLAIM PAYMENT INFORMATION *(Contact and address where payment should be sent)*

*CHECK PAYABLE TO

*STREET ADDRESS

*CITY

*STATE

*ZIP CODE

EMAIL

FAX NUMBER

*NPI NUMBER *(If submitted by provider)*

*TAX ID NUMBER *(If submitted by provider)*

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