Pfizer IGuide™ Co-Pay Claim Form

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

Eligibility

Patients may be eligible for this offer if they:

- **Have commercial insurance that covers:**
  - **CUTAQUIG**
  - **OCTAGAM**
  - **PANZYGA**
- **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 to the Pfizer IGuide co-pay program for CUTAQUIG, OCTAGAM, or PANZYGA:

1. A completed claim form within 180 days of the date of service 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)

PANZYGA ONLY – For claims to the Pfizer IGuide co-pay program for the out-of-pocket infusion cost for PANZYGA, please submit the following:

1. A completed claim form within 180 days of the date of service shown on the patient's EOB
2. A copy of the EOB
3. A paid receipt if the patient has already paid upfront for the PANZYGA infusion
4. 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
430 Mountain Avenue, Suite 105, New Providence, NJ 07974

CUTAQUIG, OCTAGAM, and PANZYGA 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 apply. For full Terms and Conditions, please see pfizeriguideresources.com. Contact Pfizer IGuide if you have questions relating to your eligibility for the CUTAQUIG Co-Pay Program, OCTAGAM Co-Pay Program, or PANZYGA Co-Pay Program.

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

*Select product
☐ CUTAQUIG ☐ OCTAGAM ☐ PANZYGA

*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)

*DATE OF SERVICE
(Provide dose or dose range)

*PATIENT OUT-OF-POCKET AMOUNT FOR PRODUCT

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

*PATIENT-OUT-OF-POCKET AMOUNT FOR ADMINISTRATION

*CODE BILLED FOR ADMINISTRATION *(for PANZYGA only)* ☐ 96365 ☐ 96366 ☐ S9338

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

EMAIL

*STREET ADDRESS

*CITY

*STATE

*ZIP CODE

FAX NUMBER

*NPI NUMBER *(If submitted by provider)*

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

