Pfizer iGuide™

Pfizer IGuide™ Enrollment Form for CUTAQUIG® (Immune Globulin Subcutaneous [Human]-hipp), 16.5% solution, OCTAGAM® (Immune Globulin Intravenous [Human]), and PANZYGA® (Immune Globulin Subcutaneous [Human]-ifas) 10% solution

Please complete and fax this form to 1-844-868-6329 or mail to Pfizer IGuide™, PO Box 220692, Charlotte, NC 28222
For assistance call: 1-844-448-4337, Monday–Friday, 8 AM–8 PM ET

For details about how we collect and use personal information, including applicable US state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

PLEASE CHECK PRODUCT: ☐ CUTAQUIG ☐ OCTAGAM 5% ☐ OCTAGAM 10% ☐ PANZYGA

1. PATIENT INFORMATION (TO BE COMPLETED BY PATIENT OR HEALTHCARE PROVIDER) *INDICATES REQUIRED FIELDS

*NAME (FIRST, MI, LAST) *SEX ☐ MALE ☐ FEMALE ☐ NOT DISCLOSED

*STREET ADDRESS *CITY *STATE *ZIP

*DATE OF BIRTH (MM/DD/YY) HOME PHONE CELL PHONE OKAY TO LEAVE MESSAGE ☐

LANGUAGE PREFERENCE CAREGIVER NAME CAREGIVER RELATIONSHIP TO PATIENT CAREGIVER PHONE

2. INSURANCE INFORMATION (TO BE COMPLETED BY PATIENT OR HEALTHCARE PROVIDER) *INDICATES REQUIRED FIELDS

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD(S)

PRIMARY INSURANCE

*INSURANCE NAME *INSURANCE PHONE *POLICY/GROUP ID NUMBER

*POLICYHOLDER NAME *POLICYHOLDER RELATIONSHIP TO PATIENT GROUP NUMBER

SECONDARY INSURANCE

*INSURANCE NAME *INSURANCE PHONE *POLICY/GROUP ID NUMBER

*POLICYHOLDER NAME *POLICYHOLDER RELATIONSHIP TO PATIENT GROUP NUMBER

PRESCRIPTION INSURANCE

PRESCRIPTION INSURANCE NAME PRESCRIPTION POLICY ID NUMBER PRESCRIPTION BIN

PRESCRIPTION GROUP ID NUMBER PRESCRIPTION GROUP NUMBER PRESCRIPTION PCN

PREFERRED SITE OF CARE: ☐ SPECIALTY INFUSION PHARMACY ☐ PHYSICIAN INFUSION CLINIC

*PREFERRED SPECIALTY INFUSION PHARMACY NAME SPECIALTY PHARMACY PHONE

I authorize Pfizer and its affiliates, agents, representatives, and service providers to fax this referral to the Specialty Infusion Pharmacy designated above, provided it is approved by this patient's plan. If the Specialty Infusion Pharmacy designated is not a plan-approved Specialty or Infusion Specialty Pharmacy, then fax this referral to a Specialty Infusion Pharmacy approved by this patient's plan.

3. PRIVACY NOTICE AND CONSENT TO PROCESS HEALTH INFORMATION AND PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing below/other affirmative act, you understand that Pfizer, Inc., the Pfizer Patient Assistance Foundation, Pfizer's affiliates, and its vendors (collectively, "Pfizer") will use the health information you and your healthcare providers provide us to provide you with the Patient Support Activities. You have the right to withdraw these permissions at any time and can do so by calling Pfizer IGuide at 844-448-4337. You can find more information about how Pfizer Inc. handles your personal information in our Privacy Policy at pfizer.com/privacy.
By using the boxes below, you can also agree to permit Pfizer to use the information you provide for additional specified purposes:
I understand that I have the right to withdraw my consent by calling Pfizer IGuide at 844-448-4337, and that if I withdraw my consent(s) it will be effective for any future disclosures but will not affect disclosures already made.

☐ I understand and consent to the terms of the Privacy Notice and Consent to Process Health Information

By signing this form, I agree to receive calls and texts from Pfizer or parties acting on its behalf, including calls and texts that use an autodialer or include artificial/prerecorded voice, to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, refill reminders from Pfizer IGuide, information and other Patient Support Activities (such as copay support or free drug programs) and for other non-marketing purposes (such as enrollment status and shipping updates) at the telephone number(s) I provide. I understand that my consent is not required and is not a condition of purchasing any goods or services from Pfizer. Message and data rates may apply. Text HELP to 82000 for information and STOP to opt out.

If I have a caregiver, he or she has also agreed to receive calls and texts, including calls and texts that use an autodialer or include artificial/prerecorded voice and hereby gives his or her permission for Pfizer, Pfizer IGuide, and/or parties acting on their behalf to contact him or her for such purposes at the phone number(s) provided. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer IGuide at 844-448-4337, Monday-Friday, 8AM - 8PM ET.

SIGN HERE

*Patient Signature (Patient or Patient Representative) *Print Name of Patient

Patient Representative Name
(Please print. Required if signing on behalf of the patient) *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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* PATIENT NAME (FIRST, MI, LAST)

4. PATIENT CONSENT AND ATTESTATION IF REQUESTING CO-PAY ASSISTANCE (REQUIRED IF APPLYING FOR CO-PAY ASSISTANCE)

☐ Yes ☐ No I attest that I am not enrolled in a state- or federally funded insurance program, including but not limited to, Medicare, Medicaid, TRICARE, Veterans Affairs healthcare, a state prescription drug program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud"). I attest that I am not over 65 years of age and retired. I attest that I do not receive Social Security Disability (SSDI) or any other Social Security Administration (SSA) benefit. I further attest that I am not active duty military nor are any of my immediate family members.

☐ By checking this box, I confirm that I am eligible to participate in this program and agree to the Terms and Conditions specified here or available here. Please agree to the Terms and Conditions before proceeding.

How do you prefer to receive your Co-Pay Program Welcome Message?

☐ TEXT TO PHONE NUMBER OR ☐ EMAIL TO EMAIL ADDRESS

SIGN HERE

*Patient Signature (Patient or Patient Representative) *Print Name of Patient

Patient Representative Name
(Please print. Required if signing on behalf of the patient) *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 _____

If you have questions relating to your eligibility for the CUTAQUIG Co-Pay Assistance Program, OCTAGAM Co-Pay Assistance Program, or PANZYGA Co-Pay Assistance Program, you can contact Pfizer IGuide™ and provide your commercial insurance information to verify eligibility. Terms and Conditions apply. For full Terms and Conditions for CUTAQUIG, PANZYGA, and OCTAGAM, please click here. Pfizer understands that your personal and health information is private and will only use your information in accordance with our Privacy Policy. The information you provide will only be used by Pfizer and parties acting on its behalf to send you the materials you requested as well as other helpful product and/or related product information, disease state information, offers, and services.

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* PATIENT NAME (FIRST, MI, LAST)

5. HEALTHCARE PROVIDER INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER. ALL FIELDS MUST BE COMPLETED)

*INDICATES REQUIRED FIELDS

*PRESCRIBER NAME (FIRST/MI/LAST)

*PRACTICE/ INSTITUTION NAME

*SPECIALTY

*STREET ADDRESS

*CITY

*STATE

*ZIP

*OFFICE PHONE

*OFFICE FAX

*OFFICE CONTACT

*OFFICE CONTACT PHONE NUMBER

*GROUP TAX ID

*NPI NUMBER

*STATE LICENSE NUMBER

6. PRESCRIPTION (NOTE — THIS SECTION IS ONLY TO BE COMPLETED IF YOU WANT PFIZER IGUIDE™ TO FORWARD THE PRESCRIPTION TO THE SPECIALTY PHARMACY FOR YOU. TO BE COMPLETED BY HEALTHCARE PROVIDER. ALL FIELDS MUST BE COMPLETED) *INDICATES REQUIRED FIELDS

*PATIENT NAME (FIRST, MI, LAST)

*DOB

*PRIMARY DIAGNOSIS CODE:

PATIENT WEIGHT (KG):

PRESCRIPTION:

- ☐ **CUTAQUIG® (IMMUNE GLOBULIN SUBCUTANEOUS [HUMAN]-HIPP), 16.5% SOLUTION** (REFER TO PRESCRIBING INFORMATION FOR DOSING INSTRUCTIONS)
- ☐ **OCTAGAM® 10% (IMMUNE GLOBULIN INTRAVENOUS [HUMAN]), LIQUID PREPARATION** (REFER TO PRESCRIBING INFORMATION FOR DOSING INSTRUCTIONS)
- ☐ **OCTAGAM® 5% (IMMUNE GLOBULIN INTRAVENOUS [HUMAN]), LIQUID PREPARATION** (REFER TO PRESCRIBING INFORMATION FOR DOSING INSTRUCTIONS)
- ☐ **PANZYGA® (IMMUNE GLOBULIN INTRAVENOUS [HUMAN]-IFAS), 10% LIQUID PREPARATION** (REFER TO PRESCRIBING INFORMATION FOR DOSING INSTRUCTIONS)

INFUSE G INTRAVENOUSLY EVERY WEEKS *HAS THE PATIENT USED IG OR SCIG THERAPY BEFORE? YES ☐ NO ☐

TOTAL NUMBER OF INFUSIONS REQUESTED: SUFFICIENT SUPPLY FOR INFUSIONS

(BASED ON THE NUMBER OF WEEKS REQUESTED AND PATIENT BODY WEIGHT) REFILLS (AS ALLOWED BY STATE OR PAYER REQUIREMENTS)

☐ NO KNOWN DRUG ALLERGIES

DRUG ALLERGIES:

☐ NO OTHER MEDICATIONS

CONCURRENT MEDICATIONS:

***SIGNATURE OF HEALTHCARE PROVIDER (NO STAMPS)**

***COLLABORATIVE PHYSICIAN NAME (IF APPLICABLE):**

***PRINTED NAME OF HEALTHCARE PROVIDER**

DATE

DISPENSE AS WRITTEN: EXACT TERMINOLOGY MAY BE BASED ON STATE REGULATIONS. PLEASE PROVIDE STATE TERMINOLOGY HERE:

7. HEALTHCARE PROVIDER SIGNATURE

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.

I also give my permission to receive calls related to these services from Pfizer, Pfizer IGuide™, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

***SIGNATURE OF HEALTHCARE PROVIDER**

DATE

DISCLAIMER

Insurance verification is the ultimate responsibility of the provider. Benefit information provided by Pfizer IGuide™ is not a guarantee of insurance coverage or reimbursement. All benefit information is subject to the insured patient's plan at the time services are rendered. Under no circumstances shall Pfizer IGuide™ be held responsible or liable for payment of any claims, benefits, or cost. Any coding information obtained from Pfizer IGuide™ is provided for informational purposes only, is subject to change, and should not be construed as legal advice. Providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to the specific patient.

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8. PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

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 (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 me with disease management and other educational materials, as well as information about Pfizer products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs
- Pfizer also may use my health information for quality assurance purposes and to evaluate and improve our 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, Pfizer IGuide™ 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. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me.

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 I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact Pfizer IGuide™ at PO Box 220692, Charlotte, NC 28222, 1-844-448-4337, Monday–Friday, 8 AM–8 PM ET. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I will receive a signed copy of this form.

***PATIENT SIGNATURE** ***PRINT NAME OF PATIENT** ***DATE**

*Patient name or name of personal representative. If personal representative of patient, please complete the fields below.

PATIENT REPRESENTATIVE SIGNATURE **PRINT NAME OF PATIENT REPRESENTATIVE** **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