Pfizer IGuide™ Enrollment Form for PANZYGA®

panzyga®
Immune Globulin Intravenous (Human) - ifas
10% Liquid Preparation

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 U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

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. PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing this form, I agree to communications from Pfizer, Pfizer IGuide™, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer, Pfizer IGuide™, or parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number(s) provided. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Pfizer IGuide™, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer IGuide™, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer IGuide™ at 1-844-448-4337, Monday–Friday, 8 AM–8 PM ET.

***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

* PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)

4. PATIENT CONSENT AND ATTESTATION IF REQUESTING CO-PAY ASSISTANCE

Co-Pay Program Consent and Attestation: The checkboxes below must be completed if you are requesting enrollment in the Pfizer IGuide™ Co-Pay Assistance Program.

☐ Yes ☐ No I authorize the Pfizer IGuide™ Co-Pay Assistance Program for PANZYGA to provide payment directly to my healthcare provider, and not to me, for my out-of-pocket drug costs for PANZYGA. I authorize my healthcare provider to contact the Program on my behalf to initiate payment for services after they have been rendered. I understand that I will be responsible for any out-of-pocket expenses for PANZYGA if (1) my healthcare provider does not request payment within 180 days of the issue date on my Explanation of Benefits (EOB), or (2) if I am deemed ineligible for reimbursement from the Program. To be eligible for this program, you must be commercially insured and not be enrolled in a state- or federally funded insurance program. Please see full terms and conditions.

☐ 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 health care, 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 Insurance (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.

☐ Yes ☐ No I confirm that I am eligible to participate in this program and agree to the below Terms and Conditions.

*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

TERMS AND CONDITIONS

By using this co-pay card, 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 this 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 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. Patient must be 2 years of age or older to be eligible for the co-pay benefit. Co-pay card cannot be combined with any other savings, free trial, or similar offer for the specified prescription. **Co-pay 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. Co-pay card is limited to 1 per person during this offering period and is not transferable. A co-pay card may not be redeemed more than once per 13 days per patient. 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 12/31/2023.

For more information, call 1-866-642-7606, visit https://panzyga.pfizerpro.com/support/co-pay-program-for-patients or write:

Panzyga Co-Pay Program

PO Box 6875

Bridgewater, NJ 08807

Pfizer IGuide™ Enrollment Form for PANZYGA®

panzyga®
Immune Globulin Intravenous (Human) - ifas 10% Liquid Preparation

* PATIENT NAME (FIRST, MIDDLE INITIAL, 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

PRESCRIPTION: PANZYGA® (IMMUNE GLOBULIN INTRAVENOUS, [HUMAN]-IFAS) 10% LIQUID PREPARATION *REFER TO PRESCRIBING INFORMATION FOR DOSING INSTRUCTIONS

*PATIENT NAME (FIRST, MI, LAST)

*DOB

*PRIMARY DIAGNOSIS CODE:

*HAS THE PATIENT USED IG OR SCIG THERAPY BEFORE? YES ☐ NO ☐

IF YES, PLEASE LIST WHICH PRODUCTS:

PATIENT WEIGHT (KG): INFUSE G INTRAVENOUSLY EVERY WEEKS

TOTAL NUMBER OF INFUSIONS OF PANZYGA® REQUESTED: SUFFICIENT SUPPLY FOR INFUSIONS

DRUG ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES CONCURRENT MEDICATIONS: ☐ NO OTHER MEDICATIONS

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

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

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

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

***PRINTED NAME OF HEALTHCARE PROVIDER**

DATE

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.

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.

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, depending on your 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 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 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, 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. 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 me.

I understand that this form will remain in effect for 4 years from the date of my signature unless 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 withdrew my approval. I understand I may receive a 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