XELSOURCE℠
Answers and Support

Prescription Information and XELSOURCE℠ Enrollment Form

Please complete and fax this form to 1-866-297-3471. For assistance or additional information, call 1-855-4-XELJANZ (493-5526), Monday–Friday, 8 am–8 pm ET

1. PATIENT INFORMATION

NAME (First, MI, Last)_____ DOB (MM/DD/YYYY)_____ GENDER_____

ADDRESS_____ CITY_____

STATE_____ ZIP CODE_____ E-MAIL_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____ BEST TIME TO CONTACT_____

ALLERGIES_____ OTHER MEDICATIONS_____

2. INSURANCE INFORMATION [Please attach copies of both sides of patient's insurance card(s)]

❑ **CHECK IF PATIENT DOES NOT HAVE INSURANCE**

PRIMARY INSURANCE_____ INSURANCE TELEPHONE_____

POLICY ID #_____ GROUP #_____

POLICY HOLDER NAME (FIRST, LAST) AND RELATIONSHIP TO PATIENT _____

PHARMACY PLAN NAME_____ PREFERRED SPECIALTY PHARMACY Avella Specialty Pharmacy

POLICY ID #_____ GROUP #_____ RX BIN # _____ RX PCN #_____

3. PATIENT AGREEMENT TO ENROLL IN XELSOURCE AND TO USE OF PROTECTED HEALTH INFORMATION

My signature below certifies that: (A) I agree to enroll in XELSOURCE; (B) I have provided my doctor with an authorization to release my protected health information to Pfizer Inc and its affiliates, agents and service providers (including but not limited to HealthBridge, Inc.) and specialty pharmacies in connection with the XELSOURCE Program; (C) I agree that Pfizer Inc and its affiliates, agents and service providers may receive, use and disclose my protected health information in connection with the XELSOURCE Program (including but not limited to communicating with my insurer, specialty pharmacies and others involved in processing my pharmacy claims, to verify my coverage and benefits); (D) I also agree that Pfizer or companies acting on its behalf may send me materials and other helpful information on rheumatoid arthritis and XELJANZ® (tofacitinib citrate) 5 mg tablets, as well as related treatments, products, offers and services.

PATIENT SIGNATURE X_____ DATE_____ PATIENT NAME_____

If patient cannot sign, patient's legally authorized representative must sign below.

PATIENT NAME_____ BY X_____

Signature of person legally authorized to sign for patient/relationship

4. PRESCRIBER INFORMATION

PRESCRIBER NAME (First, Last)_____ SPECIALTY_____

PRACTICE NAME _____ OFFICE CONTACT_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

E-MAIL_____ PHONE_____ FAX_____

MEDICAID/MEDICARE PROVIDER #_____ TAX ID#_____

STATE LICENSE #_____ NPI #_____

5. CLINICAL INFORMATION

DIAGNOSIS ❑ 714.0 Rheumatoid Arthritis ❑ 714.2 Other Rheumatoid Arthritis with visceral or systemic involvement

PRIOR MEDICATIONS ❑ Azulfidine™ ❑ Cimzia® ❑ Corticosteroids ❑ Enbrel® ❑ Humira® ❑ Indocin® ❑ Methotrexate ❑ Orencia® ❑ Remicade® ❑ Simponi® ❑ Other_____

6. PRESCRIPTION INFORMATION [■ Check to request benefits investigation only. If checked, please sign below and leave Rx information blank]

By signing this form, I certify that therapy with XELJANZ is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current XELJANZ prescribing information. I have received the necessary authorization to release medical and/or other patient information relating to XELJANZ therapy to Pfizer and its affiliates, service providers, and agents (including Healthbridge, Inc.) to use and disclose my patient's health information as necessary to participate in the XELSOURCE program, to verify the accuracy of any information provided, to provide reimbursement services, to forward the prescription below to a pharmacy for fulfillment, and (as applicable) to assess my patient's eligibility for patient assistance.

XELJANZ FREE OFFER – TRIAL Rx*: ❑ 5 mg PO BID (14 days, 28 tablets)

X_____ X_____

Doctor/Prescriber Signature — Dispense as Written Date | Doctor/Prescriber Signature — Substitution Permissible Date

XELJANZ Rx: ❑ 5 mg tablets (30 days, 60 tablets) **DIRECTIONS:** ❑ Take 5 mg PO BID **REFILLS** #: _____

X_____ X_____

Doctor/Prescriber Signature — Dispense as Written Date | Doctor/Prescriber Signature — Substitution Permissible Date

Please see Important Safety Information on back, and accompanying full Prescribing Information, including boxed warning and Medication Guide.

If you are a New York prescriber, please use an original New York State prescription form.

* Trial Rx is a one-time-only offer for eligible, commercially insured patients being prescribed XELJANZ for its FDA-approved indication. Offer only available to patients that have a diagnosis code of 714.0 Rheumatoid Arthritis or 714.2 Other Rheumatoid Arthritis with visceral or systemic involvement. The free product provided under the Trial Rx Program offer is for commercially insured patients only and does not require, nor will be made contingent on, purchase requirements of any kind. Trial Rx can only be dispensed by the exclusive pharmacy retained for this program. Please see accompanying program restrictions and conditions of use.

Pfizer's service provider performing XELSOURCE[SM] support services provides patient insurance benefit verification as a service under contract for Pfizer Inc. XELSOURCE support services assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Many factors affect third-party reimbursement. Pfizer Inc and Pfizer's service provider performing the XELSOURCE support services make no representation or guarantee that insurance reimbursement or any other payment will be available. This information is provided as an information service only. While Pfizer's service provider performing XELSOURCE support services tries to provide correct information, it and Pfizer Inc make no representations or warranties, expressed or implied, as to the accuracy of the information. The support services administrator, or Pfizer Inc, or its employees or agents shall in no event be liable for any damages resulting from or relating to the services. Responsibility for the use of this service is agreed upon and accepted by all providers and other users of this information.

Pfizer Inc does not guarantee, and assumes no responsibility for, the quality, scope, or availability of the XELSOURCE support services including but not limited to reimbursement support services, patient education, and other support services. XELSOURCE support services are included within the cost of the product, and have no independent value to providers apart from the product.

INDICATION

- XELJANZ® (tofacitinib) is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to methotrexate. It may be used as monotherapy or in combination with methotrexate or other nonbiologic disease-modifying antirheumatic drugs (DMARDs).
- XELJANZ should not be used in combination with biologic DMARDs or with potent immunosuppressants such as azathioprine and cyclosporine.

IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS INFECTIONS AND MALIGNANCY

***See* full prescribing information *for complete Boxed Warning*.**

- **Serious infections leading to hospitalization or death, including tuberculosis and bacterial, invasive fungal, viral and other opportunistic infections, have occurred in patients receiving XELJANZ.**
- **If a serious infection develops, interrupt XELJANZ until the infection is controlled.**
- **Prior to starting XELJANZ, perform a test for latent tuberculosis; if it is positive, start treatment for tuberculosis prior to starting XELJANZ.**
- **Monitor all patients for active tuberculosis during treatment, even if the initial latent tuberculosis test is negative.**
- **Lymphoma and other malignancies have been observed in patients treated with XELJANZ. Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed at an increased rate in renal transplant patients treated with XELJANZ and concomitant immunosuppressive medications.**

WARNINGS AND PRECAUTIONS

- Serious Infections — Do not administer XELJANZ during an active infection, including localized infections. If a serious infection develops, interrupt XELJANZ until the infection is controlled.
- Lymphomas and other malignancies have been reported in patients treated with XELJANZ.
- Gastrointestinal Perforations — Use with caution in patients that may be at increased risk.
- Laboratory monitoring — Recommended due to potential changes in lymphocytes, neutrophils, hemoglobin, liver enzymes, and lipids.
- Immunizations — Live vaccines should not be given concurrently with XELJANZ.
- Severe hepatic impairment — Not recommended.

ADVERSE REACTIONS

The most commonly reported adverse reactions during the first 3 months in controlled clinical trials (occurring in greater than or equal to 2% of patients treated with XELJANZ monotherapy or in combination with DMARDs) were upper respiratory tract infections, headache, diarrhea and nasopharyngitis.

Please see accompanying full Prescribing Information, including boxed warning and Medication Guide.

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HIPAA Authorization Form for the Disclosure of Patient Information

To PATIENT:

The attached Authorization is for you and your doctor. If you sign this Authorization, you are allowing your doctor to give Pfizer health information about you that will help you get your Pfizer medications. An example of the type of information we need from your doctor would be the prescription for the medicine you need. This Authorization is between you and your doctor only. **Please sign and give your doctor the original signed Authorization and keep a copy for your records. This form should not be returned with your application.**

To PHYSICIAN:

The attached Authorization, when signed by your patient, documents the patient's permission for you to share certain medical and personal information with Pfizer in connection with Pfizer's patient assistance programs. **This Authorization is strictly for your records and should not be returned with your patient's application.**

To PATIENT and PHYSICIAN, please note:

XELSOURCE℠ is powered by Pfizer Helpful Answers®. Pfizer Helpful Answers® is a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation™, Inc.

Please see accompanying full Prescribing Information, including boxed warning and Medication Guide.

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HIPAA Authorization Form for the Disclosure of Patient Information

To the Patient: Please complete this Authorization, sign and date it, and return it to your doctor.

To the Physician: Please retain the original signed Authorization with the patient's records and provide a copy to the patient. You do not need to return this patient Authorization to Pfizer.

I request and authorize my doctor, _____ ("Doctor"), to give Pfizer Inc, its affiliates, agents and service providers who work on behalf of Pfizer (including but not limited to Healthbridge, Inc. and specialty pharmacies), information about me and my medical condition, which is necessary to determine my eligibility for XELSOURCE℠ support services and for my continuing participation in XELSOURCE if I am accepted, to administer XELSOURCE, to account for my withdrawal if I decide to stop participating in XELSOURCE, and to evaluate patient satisfaction and the overall effectiveness of XELSOURCE. The type of information that can be given under this authorization may include:

- My name and birth date
- My address and telephone number
- My social security number
- Financial information about me
- Information about my health benefits or health insurance coverage
- Information on my medical condition, as necessary

I know that I can cancel this Authorization at any time by writing to my Doctor at _____. If I cancel this authorization, then my Doctor will stop providing Pfizer, and its representatives, with information about me. However, I cannot cancel actions that have already been taken by relying on my Authorization.

I understand that once my Doctor gives Pfizer Inc, its affiliates, agents and service providers who work on behalf of Pfizer (including but not limited to HealthBridge, Inc. and specialty pharmacies) information about me based on this Authorization, federal privacy laws may not prevent Pfizer from further disclosing my information. I also understand that signing this Authorization does not guarantee that I will be accepted into a Pfizer patient assistance program.

This Authorization will expire one (1) year after the date it is signed, below.

Patient or Personal Representative of Patient (Authority to sign on behalf of Patient [if applicable])

Signature _____

Date _____

Name (please print) _____

Please return the signed form to your Doctor. You are entitled to a copy for your records.

Please see accompanying full Prescribing Information, including boxed warning and Medication Guide.