Pfizer genetogether™

BEQVEZ™ (fidanacogene elaparvovec-dzkt) Enrollment Form for Patient

Go to www.pfizergenetogether.com to complete this form online. For assistance, call 1-888-733-2030, M-F, 8AM-8PM EST

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

1 PATIENT INFORMATION (*REQUIRED)

Patient Name

First name*_____ Middle name _____

Last name*_____ Date of Birth (mm/dd/yyyy)*_____

Sex* ☐ Male ☐ Female (Sex describes one's biology at birth)_____ Gender ☐ Male ☐ Female ☐ Other (Gender describes how one identifies oneself)

Address*_____ Floor/Suite/Unit _____

City*_____ State*_____ ZIP*_____

Primary Phone*_____ ☐ M ☐ H ☐ W Alternate Phone _____ ☐ M ☐ H ☐ W

Preferred Language ☐ English ☐ Spanish Leave a Message Preference ☐ Y ☐ N Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening

Email _____ Preferred Communication Channel ☐ Email ☐ SMS

Primary Caregiver

First Name _____ Last Name _____

Caregiver Relationship to Patient ☐ Guardian ☐ Court Appointed ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

Primary Phone _____ ☐ M ☐ H ☐ W Alternate Phone _____ ☐ M ☐ H ☐ W

Preferred Language ☐ English ☐ Spanish Leave a Message Preference ☐ Y ☐ N Best Time to Contact ☐ Morning ☐ Afternoon ☐ Evening

Email _____ Preferred Communication Channel ☐ Email ☐ SMS

2 INSURANCE INFORMATION (*REQUIRED)

☐ Check If Patient Does Not Have Insurance

Primary Insurance Information

Primary Payer*_____ Insurer's Phone*_____

Policy ID #*_____ Group #*_____

Policyholder Name _____ Policyholder DOB _____

Policyholder Relationship to Patient ☐ Guardian ☐ Court Appointed ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

Payer type ☐ Commercial ☐ Government ☐ Medicare ☐ Medicaid ☐ Other _____

Secondary Insurance Information

Secondary Payer _____ Insurer's Phone _____

Policy ID # _____ Group # _____

Policyholder Name _____ Relationship to Patient _____ Policyholder DOB _____

☐ Commercial ☐ Government ☐ Medicare ☐ Medicaid ☐ Other _____

Primary Pharmacy Benefit Information

Primary Payer*_____ Insurer's Phone*_____

Policy ID #*_____ Group #*_____ Rx Bin # _____ Rx PCN # _____

Policyholder Name _____ Policyholder DOB _____

Policyholder Relationship to Patient ☐ Guardian ☐ Court Appointed ☐ Power of Attorney, including authority to make healthcare decisions ☐ Other _____

Payer type ☐ Commercial ☐ Government ☐ Medicare ☐ Medicaid ☐ Other _____

Fax complete form to 1-646-862-9653 or mail to 600 Emerson Road 3rd Floor, Suite 300 Creve Coeur, MO 63141.

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3 GENE INFUSION CENTER INFORMATION (*REQUIRED)

Please Select Billing Method

☐ Buy and Bill ☐ Preferred Specialty Pharmacy Name: _____

Please note: Product is available through limited Specialty Pharmacies. Actual billing method may be specified by the patient's insurance.

Practice/Institution Name*_____

Address*_____ Floor/Suite/Unit _____

City*_____ State*_____ ZIP*_____

NPI #*_____ Group Tax ID # _____ State License #*_____

Email*_____ Office Phone*_____ Fax*_____

Preferred Contact First Name*_____ Preferred Contact Last Name*_____

GIC Affiliation _____

4 TREATING PHYSICIAN INFORMATION (*REQUIRED)

Treating Physician Name

First*_____ Middle _____ Last*_____

Specialty*_____

NPI #*_____ Group Tax ID # _____ State License #*_____

Email*_____ Office Phone*_____ Fax*_____

5 DIAGNOSIS (*REQUIRED)

☐ Primary ICD-10 Code D67* ☐ Secondary ICD-10 Code _____

6 RECOMMENDED DOSAGE

Calculation of a patient's dose weight: BEQVEZ dosing is based on the patient's body mass index (BMI) in kg/m^2.

Patient's BMI	Patient's Dose Weight
<30 kg/m^2	Dose Weight = Actual body weight
>30 kg/m^2	Determine using the following calculation: Dose weight (kg) = 30 kg/m^2 x [Height (m)]^2

Calculation of a patient's dose volume in milliliters (mL): Dose weight in kilograms (kg) divided by 20 = dose in mL.
The division factor 20 represents the amount of vector genomes per mL of the BEQVEZ solution (1 x 10^{13} vg/mL) divided by the per kilogram dose (5 x 10^{11} vg/kg). Examples of dose volume calculation:

Patient's Weight, Height, and BMI	Patient's Dose Weight Calculation if BMI >30 kg/m^2	Patient's Dose Weight	Patient's Dose Volume (Body Weight Divided by 20)
80 kg, 1.84 m, 23.6 kg/m^2	No adjustment	80 kg	4 mL
120 kg, 1.84 m, 35.4 kg/m^2	30 kg/m^2 x [1.84 (m)]^2	101.6 kg	5.08 mL

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7 MEDICAL INFORMATION (*REQUIRED)

Patient Name

First* _____ Middle _____ Last* _____ Date of Birth (mm/dd/yyyy)* _____

FDA approved companion diagnostic test Companion Diagnostics Test Ordered*: ☐ Yes ☐ No Date of Blood Draw* _____

Prior/Current Treatment (if any) _____ Last Date of Prior/Current Treatment _____

Other Instructions _____

Known Drug Allergies: ☐ Yes ☐ No If yes, please list medication(s) and associated reaction(s) _____

_____

_____

Patient Dosing Weight (kg)* _____ Date Weight Taken (mm/dd/yyyy)* _____ Body mass index (BMI)* _____

Please see section 6 of this form for recommended dosage.

Expected Infusion Date (mm/dd/yyyy)* _____

BEQVEZ is an adeno-associated viral vector-based gene therapy indicated for the treatment of hemophilia B in patients ≥18 years of age. BEQVEZ is supplied as a clear to slightly opalescent, colorless to slightly brown solution with each mL containing 1 x 1013 vg/mL. BEQVEZ is provided as a customized treatment pack containing the number of vials required to meet dosing requirements for each patient. BEQVEZ is a solution for intravenous infusion. BEQVEZ has a nominal concentration of 1 x 1013 vg/mL, and each vial contains an extractable volume of 1 mL. The total number of vials will be customized to meet dosing requirements for individual patients based on their weight.

Administer BEQVEZ as an intravenous infusion after dilution in 0.9% sodium chloride with 0.25% human serum albumin (HSA) over approximately 60 minutes.

For single-dose intravenous infusion only.

Patient Dosing Weight Range (kg)	NDC Number	Patient Dosing Weight Range (kg)	NDC Number
☐ ≤75 kgs	0069-2004-04	☐ >95 to ≤115 kgs	0069-2006-06
☐ >75 to ≤95 kgs	0069-2005-05	☐ >115 to ≤135 kgs	0069-2007-07

8 REFERRING HCP INFORMATION (*REQUIRED)

First Name* _____ Middle Name _____ Last Name* _____

Specialty* _____ Phone* _____ Fax* _____

Email* _____ NPI #* _____

Practice/Facility Name* _____

Office Contact First Name* _____ Office Contact Last Name* _____

Office Contact Email* _____ Office Contact Phone* _____ Office Contact Fax* _____

Office Street Address* _____ City* _____ State* _____ ZIP* _____

Office NPI #* _____ Referral Date* _____

9 TREATING PHYSICIAN CERTIFICATION (*REQUIRED)

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.

☐ **Dispense as written: Prescriber Signature*** _____ **Date*** _____

☐ **Substitution allowed: Prescriber Signature** _____ **Date** _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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10 PATIENT FINANCIAL INFORMATION (OPTIONAL FOR TRAVEL ASSISTANCE)

Total Number of People Within the Household (including applicant) _____ Total Annual Income for the Entire Household ($) _____

If you do not want your income verified electronically, you must submit documentation to support the financial information you've listed. Acceptable forms of income documentation for all members of the household include the following:

☐ Most recent federal tax return 1040/1040-SR ☐ W-2 form ☐ Other _____

Patient Authorization for Electronic Income Verification (OPTIONAL FOR TRAVEL ASSISTANCE)

☐ **By checking this box and signing below,** I, the applicant named below, understand that I am providing "written instructions" to Pfizer GeneTogether under the Fair Credit Reporting Act authorizing Pfizer GeneTogether to obtain information from my credit profile or other information from Experian. I authorize Pfizer GeneTogether to obtain such information solely for the purpose of determining financial qualifications.

Patient Signature (Patient or patient representative must be 18 or older)† _____ **Date** _____

Patient representative name (please print)‡ _____ **Date** _____

If signed by patient representative, please indicate below the authority to act on behalf of the patient§:

☐ **Court Appointed** ☐ **Guardian** ☐ **Power of Attorney, including authority to make healthcare decisions** ☐ **Other** _____

11 PATIENT SUPPORT OPT-IN (*REQUIRED)

Personalized patient support is offered through Pfizer GeneTogether. You can speak with the Pfizer GeneTogether Patient Case Manager for resources that may help with your daily life. Your Pfizer GeneTogether Patient Case Manager may provide information about your condition, Pfizer GeneTogether medicine, or topics such as nutrition, as well as a co-pay card offer for eligible patients. The Pfizer GeneTogether Patient Case Manager can also connect you to independent organizations that provide services such as transportation and lodging for your treatment-related appointments. These offerings may vary based on your prescribed Pfizer medicine.

To opt-in to this program, please check the box below:

☐ ***By checking this box, I request the Pfizer GeneTogether Patient Case Manager support and agree to communications from Pfizer GeneTogether, Pfizer, and/or parties acting on their behalf. These communications may include calls to my phone number made with an autodialer about resources and other support such as those described above. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services. I understand that I can opt out of these communications at any time by contacting Pfizer GeneTogether at 1-888-733-2030.

12 PATIENT PRIVACY NOTICE AND CONSENT TO PROCESS HEALTH INFORMATION (*REQUIRED)

By checking the box below, 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 contacting Pfizer GeneTogether at 1-888-733-2030. You can find more information about how Pfizer Inc. handles your personal information in our Privacy Policy at pfizer.com/privacy.

I understand that I have the right to withdraw my consent by calling 1-888-733-2030, and that if I withdraw my consent 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.**

13 PATIENT CONSENT TO RECEIVE COMMUNICATIONS (*REQUIRED)

By providing my mobile number and checking the box below, I or my caregiver agree to receive calls and texts from Pfizer or parties acting on its behalf, to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, refill reminders from Pfizer GeneTogether, 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 or my caregiver provide.

Please enter the mobile number you would like to enroll for texting _____ – _____ – _____

☐ ***I or my caregiver agree to receive calls and texts from Pfizer or parties acting on its behalf as stated.**

I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer GeneTogether at 1-888-733-2030. 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. Complete terms can be found at https://www.pfizergenetogether.com/sms-terms and Pfizer's privacy policy at www.pfizer.com/privacy. Text STOP to opt out.

By providing my signature, I confirm that I completed this form, including any authorizations/consents/check-boxes.

Patient Signature* (Patient or patient representative must be 18 or older)† _____ **Date*** _____

Patient representative name (please print)‡ _____ **Date** _____

If signed by patient representative, please indicate below the authority to act on behalf of the patient§:

☐ **Court Appointed** ☐ **Guardian** ☐ **Power of Attorney, including authority to make healthcare decisions** ☐ **Other** _____

†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
‡NOT required if patient signs.
§Required if patient representative signs.

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14 PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (*REQUIRED)

By signing and dating 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's products, services, and programs, and may include sending me surveys about my experience with Pfizer's 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 and date this form, Pfizer GeneTogether 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 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 GeneTogether at 600 Emerson Road 3rd Floor, Suite 300 Creve Coeur, MO 63141, or at 1-888-733-2030. This withdrawal will not affect the use or sharing of my health information that took place before I withdrew my approval. I understand I will receive a copy of this form.

Patient Signature* (Patient or patient representative must be 18 or older)† _____ **Date*** _____

Patient representative name (please print)‡ _____ **Date** _____

If signed by patient representative, please indicate below the authority to act on behalf of the patient§:

☐ Court Appointed ☐ Guardian ☐ Power of Attorney, including authority to make healthcare decisions

☐ Other _____

†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.
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