PO Box 29293
Phoenix, AZ 85038-9293

844-826-8371

CoverOne.com

Pfizer Oncology Together
PO Box 220366
Charlotte, NC 28222-0366

1-877-744-5675

PfizerOncologyTogether.com

In an effort to streamline the patient enrollment process, EMD Serono and Pfizer have partnered to create a single enrollment form for the BAVENCIO® (avelumab) Injection 20 mg/mL and INLYTA® (axitinib) tablets combination that can be processed through both CoverOne and Pfizer Oncology Together. **Please fax the signed enrollment form (pages 1-4) to 855-737-7671. NOTE: The patient must sign on pages 3 and 5. The physician must sign on pages 2 and 4.**

Each program will independently conduct the access and reimbursement activities for the product for which it is responsible, based on existing business rules for each program, and separately contact you regarding your request for services.

Please only use this form for patients being treated with BAVENCIO in combination with INLYTA.

The patient is requesting assistance with the following services (check all that apply):

____ Verification of Insurance Benefits/Drug Coverage/Patient Assistance Program Pre-screening
____ Prior Authorization Assistance
____ Apply for Co-Pay Assistance (for privately insured patients only)
____ Denied/Underpaid Claims Assistance
____ Patient Assistance Program: Please apply if uninsured or you are unsure if you have insurance coverage for either of the drugs above.
Include a prescription for the patient if applying for Patient Assistance Program
____ Other ____

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth:	SSN:	Home Phone #:
Street Address (No PO Box):				Work Phone #:
City:	State:	ZIP:	Email:	Cell Phone #:
Gross Total Annual Household Income*: $	Number of People in Household:		Is patient a US resident? ☐YES / ☐NO	

INSURANCE INFORMATION - Please provide copies of all medical and pharmacy insurance cards (front and back)

Does the patient have medical benefits and/or pharmacy benefits through any private or government health insurer/payer/program? **YES** / **NO**
If "YES", please check applicable boxes and complete all that apply below.

Government Health Insurers/Payers/Programs

☐ Medicare Part A ☐ Medicare Part C (Medicare Advantage)
☐ Medicare Part B ☐ Medicare Part D - Drug Plan
List Medicare Beneficiary Identifier (or HICN if no MBI has been issued):
____

☐ Medicaid ☐ Veterans Affairs
☐ TRICARE ☐ Other: ________________

	Name of Insurer/Plan:	*Policy ID #:*	*Group #:*	*Insurer Phone #:*	*Policy Holder Name (if applicable):*
☐ **Private Insurance** - Medical (Primary) *Is this an ACA Qualified Health Plan?* ☐YES / ☐NO					
☐ **Private Insurance** - Medical (Secondary) *Is this an ACA Qualified Health Plan?* ☐YES / ☐NO					
☐ **Private** - Pharmacy Benefits Manager					

*For patients applying to the Patient Assistance Program, include before-tax wages, Social Security benefits, and any other source of household income.
NOTE: Please include income documentation if applying for the Patient Assistance Program.

PHYSICIAN INFORMATION

Treating Physician Name:			Physician Email:	
State License #:	NPI:		Physician Tax ID #:	PTAN:
Facility Name:	Street Address (No PO Box):			
City:	State:		ZIP:	
Office Contact Name:	Phone:		Office Contact Email:	Fax:

PATIENT MEDICAL INFORMATION:

Primary ICD-10-CM code: Secondary ICD-10-CM code:

List Planned BAVENCIO Dates of Service:

Is patient being treated with BAVENCIO® (avelumab) in combination with INLYTA® (axitinib)?

☐YES / ☐NO

BAVENCIO Site of Care

☐ Physician Office ☐ Outpatient Hospital ☐ Other: ______________________

INLYTA® (axitinib) SECTION

List Patient Preferred Specialty Pharmacy:

Prescription Information/Direction (Required if prescribing INLYTA):

First Name:	Middle Name:	Last Name:	Date of Birth:

Please check the medicine prescribed and indicate strength & quantity.

☐ INLYTA ☐ __________mg, 30-day supply

Directions/Dosing Instructions:

☐ Dispense as Written ☐ May Substitute

Indicate number of refills:

List Drug Allergies: ☐YES / ☐NO

(If yes, please list medication[s] and associated reaction[s])

Other Known Conditions

Please note: When e-prescribing, if you cannot find the AmeriPharm (NPI number–1073692745, NCPDP number–4351968), you can also search for MedVantx under retail pharmacies (NPI number–1235371535; NCPDP number–44354180). The prescription will be sent to the same place.

List Concomitant Medications:

Patient shipping Information required for INLYTA. Check if same as above ☐

Shipping Contact ______________________ Contact Phone # ______________________

Shipping Address for Patient ______________________ City ______________________ State __________ ZIP Code __________

PHYSICIAN SIGNATURE – I authorize Pfizer, Pfizer Oncology Together and its affiliates, agents, representatives and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

Physician Name (print) ______________________

Physician Signature (required) ______________________ Date __________

Patient Consent for CoverOne and Pfizer Oncology Together Programs

By signing this CoverOne and Pfizer Oncology Together Enrollment Form, I agree, certify and attest to the following:

- The information you provide will be used by CoverOne, Pfizer Oncology Together, the Pfizer Assistance Foundation™ and parties acting on their behalf (collectively, "The Programs") to determine eligibility, to manage and improve The Programs, to help you understand your insurance coverage and help you access certain Pfizer and EMD medicines through your insurance, and/or to send you materials and other helpful information and updates relating to The Programs.
- I agree to communications from The Programs, EMD Serono, Inc. and Pfizer Inc, the companies that administer The Programs, 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 confirm that all financial and insurance information is complete and accurate. Additionally, during participation in The Programs, and while I am receiving treatment with BAVENCIO® (avelumab) in combination with INLYTA® (axitinib), I agree to immediately notify The Programs if my health insurance status changes in the future, if I obtain any new health insurance plan, or if I become entitled to, or enroll in a government health insurance program/payer (i.e. Medicare, or Medicaid).
- I understand that The Programs reserve the right to modify, change, or terminate one or both of The Programs at any time with or without notice.
- I understand that non-identifiable information from all participants in The Programs may be summarized for statistical or other purposes.
- For INLYTA, completing this enrollment form does not guarantee that I will qualify for Pfizer's assistance programs. Pfizer may contact my insurer to help me understand my insurance coverage for INLYTA and may provide me with support to obtain coverage through my insurer, including prior authorization and appeals support (if necessary and available). Pfizer may verify the accuracy of information I have provided and may ask for more financial and insurance information. Any medicine supplied by Pfizer's assistance programs shall not be sold, traded, bartered or transferred.
- The support provided through The Programs is not contingent on any future purchase.
- I give permission to The Programs to contact and leave messages for me about patient services and enrollment status. I give permission to The Programs to communicate directly with my caregiver (if applicable) on my behalf.
- For INLYTA, I consent to receive autodialed non-marketing calls/texts from Pfizer Oncology Together, Pfizer, or parties acting on their behalf. I represent that I am the account holder for the telephone number(s) I provided. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer and Pfizer Oncology Together, and/or parties acting on their behalf to contact my caregiver for such purposes. I am responsible for notifying Pfizer Inc immediately if I change my telephone number and may notify Pfizer Inc of a number change by contacting Pfizer Oncology Together.
- If I receive INLYTA provided by Pfizer through the Pfizer Patient Assistance Programs*:
  - I will promptly contact the Program if my financial status or insurance coverage changes.
  - I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription drugs.
  - I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payer, including Medicare Part D plans.
  - I will notify my insurance provider of the receipt of any medicines through the Pfizer Patient Assistance Program.
  - I have signed a copy of a current and completed HIPAA authorization form on record with my health care provider so that my health care provider may share health information about me with The Programs, Pfizer Inc, EMD Serono and the Pfizer Patient Assistance Foundation, Inc.
  - By signing this form I certify that I cannot afford my medication and I affirm that my answers and my proof-of-income documents are complete, true and accurate to the best of my knowledge.

*The Pfizer Patient Assistance Program is a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation.™ The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc with distinct legal restrictions.

PATIENT SIGNATURE – By signing below, I confirm that I have read and understand the *Patient Consent for CoverOne* and *Pfizer Oncology Together Programs* and agree to the terms on Page 3.

Patient Name (print) ____________________

Patient Signature (required) ____________________ Date __________

Legal Representative/Guardian Signature (If applicable) ____________________

Relationship to Patient ____________________ Date __________

Treating Physician Certification for CoverOne and Pfizer Oncology Together Programs

By signing this CoverOne and Pfizer Oncology Together Enrollment Form, I agree to and certify the following:

- BAVENCIO® (avelumab) in combination with INLYTA® (axitinib) is medically appropriate for the patient identified above and that I, or a physician in my Practice, will be supervising the patient's treatment.
- The CoverOne program and the Pfizer Oncology Together program are patient access programs available to assist patients, and that program participation is voluntary, and that patient eligibility for services is not connected to or contingent on any past or future purchase of BAVENCIO or INLYTA.
- If the patient applies for and is eligible for donated product through The Programs' respective Patient Assistance Programs, the medicine will be provided only to the eligible and enrolled patient at no charge of any kind. I will not seek reimbursement for such donated product administered or prescribed to the patient from any insurance company or program, including federal healthcare programs, such as Medicare and Medicaid. Additionally, I agree to notify The Programs immediately if the patient is no longer receiving BAVENCIO in combination with INLYTA through The Programs' Patient Assistance Programs, and agree to return unused donated Patient Assistance Program product to the applicable Program.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to EMD Serono and Pfizer.
- The Programs reserve the right to modify, change, or terminate one or both of The Programs at any time with or without notice.
- I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to EMD Serono, Inc. and Pfizer Inc, the companies that administer The Programs, and their employees or agents for purposes relating to The Programs' patient support activities, including benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for BAVENCIO and INLYTA.
- For INLYTA, I also give my permission to receive calls related to these services from Pfizer Oncology Together, Pfizer, Pfizer Patient Assistance Foundation, Inc., and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided. I further authorize such parties to forward this form to a pharmacy based upon patient request and (as applicable) to assess my patients' eligibility for patient assistance.
- The information provided is current, complete, and accurate to the best of my knowledge.
- I am the healthcare professional who has prescribed the therapies identified in this form and that my decision to prescribe BAVENCIO + INLYTA is based solely on my independent clinical judgment and that the therapy is medically necessary.
- I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient.
- I will receive and secure my patient's medication at my office until it's dispensed to my patient, when applicable.
- I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. NOTE: New York prescribers must submit a prescription on an original NY state prescription blank. Prescribers in all other states need to submit a state-specific blank if it is required in their state, and the application is mailed.
- Any medications supplied by Pfizer as a result of this enrollment form are for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement.
- Pfizer may contact the patient directly to confirm the receipt of INLYTA.
- The information provided on this enrollment form is subject to random audits and verification.

PHYSICIAN SIGNATURE – By signing below, I confirm that I have read and understand the *Treating Physician Certification for CoverOne and Pfizer Oncology Together Programs* and agree to the terms on this page.

Physician Name (print) ____________________

Physician Signature (required) ____________________ Date ____________

Patient Authorization to Share Health Information

By signing this form,

- I authorize my physician(s), pharmacist(s), laboratories, other healthcare providers, and health insurance companies to share my health information with CoverOne, Pfizer Oncology Together, and the Pfizer Patient Assistance Program,™* the companies that administer the CoverOne program and Pfizer Oncology Together program (collectively, "The Programs"), EMD Serono, Inc. and Pfizer Inc, which co-promote BAVENCIO® (avelumab) Injection 20 mg/ml and individuals and companies working with EMD Serono and Pfizer, the manufacturer of INLYTA® (axitinib) tablets, for the purpose of allowing The Programs to provide me with reimbursement support, patient assistance program services, and/or co-pay assistance, and/or to evaluate my eligibility for enrollment in CoverOne and/or Pfizer Oncology Together.
- I understand each of The Programs will process the information separately and will separately communicate information back to me and my healthcare provider(s).
- I understand that my health information includes information about my medical condition, treatments, insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth).
- I understand that The Programs may use my health information for quality assurance purposes and to evaluate and improve their operations and services.
- I understand that once my information is shared, federal privacy laws may no longer protect my information. I understand that I may revoke this authorization by giving written notice of my revocation to The Programs at the following respective addresses:
  - CoverOne: PO Box 29293 Phoenix, AZ 85038-9293
  - Pfizer Oncology Together: PO Box 220366 Charlotte, NC 28222-0366
- After revocation of this authorization, The Programs will stop using and disclosing my information, but the revocation will not affect prior use or disclosure of my information.
- I understand that this authorization will remain in effect for ten years for CoverOne, and one year for Pfizer Oncology Together, or such shorter period as may be required by state law, from the date of my signature, unless I revoke this authorization earlier.
- I understand that I do not have to sign this authorization and choosing not to will not affect my ability to receive BAVENCIO or INLYTA, my treatment, payment for treatment, eligibility for or enrollment in health benefits; however, such refusal will limit my ability to receive support services through The Programs.
- I understand that I have the right to receive a copy of this authorization.

Signature of Patient ______________________ Date ____________

*The Pfizer Patient Assistance Program is a joint program of Pfizer Inc and the Pfizer Patient Assistance Foundation.™ The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc with distinct legal restrictions.

EMD Serono, Inc. and Pfizer Inc do not guarantee coverage or reimbursement for BAVENCIO or INLYTA. Coverage and reimbursement decisions are made by insurance companies following the receipt of claims.

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