Instructions for Completing the Prescription and Patient Enrollment Form

eucrisa® crisaborole ointment 2%

eucrisa•4•you Personalized Patient Support

By enrolling in eucrisa•4•you Personalized Patient Support, patients will receive various support and information to help access EUCRISA, which may include the following (collectively, "Patient Support Activities"):

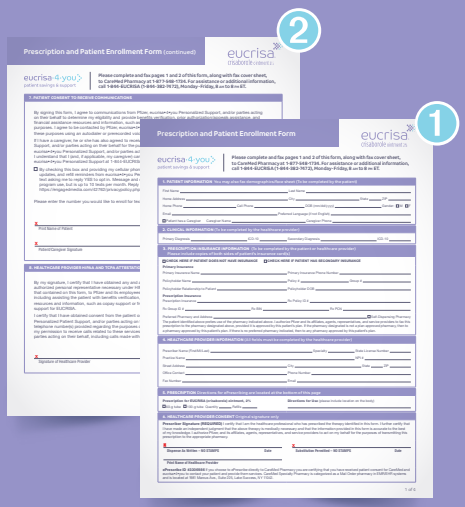
- Providing benefits investigations/verification and reimbursement support, including:
  - Assistance with prior authorization requirements from the insurer
  - Assistance with appealing any denial from the insurer
- Determining eligibility for and helping with access to copay support or free drug programs
- Communicating with healthcare providers about EUCRISA Patient Support Activities
- Provision of financial assistance resources and information, if eligible
- Provision of disease information and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending surveys about the patient's experience with Pfizer products, services, and programs

How to Complete

the eucrisa•4•you Personalized Patient Support Prescription and Enrollment Form

PAGES 1 & 2

Please complete and fax pages 1 and 2, along with fax cover sheet, to CareMed Pharmacy at 1-877-548-1734, or mail pages 1 and 2 to Pfizer Inc ("Pfizer") at 1981 Marcus Ave., Suite 225, Lake Success, NY 11042.

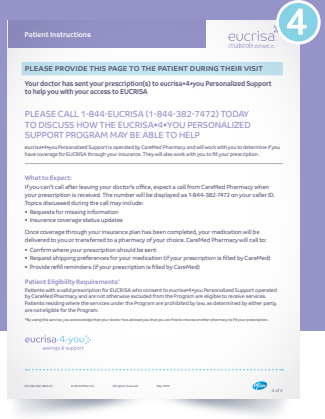


PAGE 3

Have the patient sign the Patient Authorization to Share Health Information page and add it to their file.

PAGE 4

Provide the Patient Instructions page to the patient during their visit, and advise them to call 1-844-EUCRISA upon leaving your office to avoid delays in prescription fulfillment.



Prescription and Patient Enrollment Form

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Please complete and fax pages 1 and 2 of this form, along with fax cover sheet, to CareMed Pharmacy at 1-877-548-1734. For assistance or additional information, call 1-844-EUCRISA (1-844-382-7472), Monday - Friday, 8 AM to 8 PM ET.

1. PATIENT INFORMATION You may also fax demographics/face sheet (To be completed by the patient)

First Name _____ Last Name _____

Home Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ DOB (mm/dd/yyyy) _____ Gender: ☐ M ☐ F

Email _____ Preferred Language (if not English) _____

☐ Patient has a Caregiver Caregiver Name _____ Caregiver Phone _____

2. CLINICAL INFORMATION (To be completed by the healthcare provider)

Primary Diagnosis _____ ICD-10 _____ Secondary Diagnosis _____ ICD-10 _____

3. PRESCRIPTION INSURANCE INFORMATION (To be completed by the patient or healthcare provider)

Please include copies of both sides of patient's insurance card(s)

☐ **CHECK HERE IF PATIENT DOES NOT HAVE INSURANCE** ☐ **CHECK HERE IF PATIENT HAS SECONDARY INSURANCE**

Primary Insurance

Primary Insurance Name _____ Primary Insurance Phone Number _____

Policyholder Name _____ Policy # _____ Group # _____

Policyholder Relationship to Patient _____ Policyholder DOB _____

Prescription Insurance

Prescription Insurance _____ Rx Policy ID # _____

Rx Group ID # _____ Rx BIN _____ Rx PCN _____

Preferred Pharmacy and Address _____ ☐ Self-Dispensing Pharmacy

The patient identified above prefers use of the pharmacy indicated above. I authorize Pfizer and its affiliates, agents, representatives, and service providers to fax this prescription to the pharmacy designated above, provided it is approved by this patient's plan. If the pharmacy designated is not a plan-approved pharmacy, then to a pharmacy approved by this patient's plan. If there is no preferred pharmacy indicated, then to any pharmacy approved by this patient's plan.

4. HEALTHCARE PROVIDER INFORMATION (All fields must be completed by the healthcare provider)

Prescriber Name (First/MI/Last) _____ Specialty _____ State License Number _____

Practice Name _____ NPI # _____

Street Address _____ City _____ State _____ ZIP _____

Office Contact _____ Phone Number _____

Fax Number _____ Email _____

5. PRESCRIPTION Directions for ePrescribing are located at the bottom of this page

Prescription for EUCRISA (crisaborole) ointment, 2%

☐ 60-g tube ☐ 100-g tube Quantity _____ Refills _____

Directions for Use (please include location on the body)

_____

6. HEALTHCARE PROVIDER CONSENT Original signature only

Prescriber Signature (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.

X _____ X _____

Dispense As Written – NO STAMPS **Date** **Substitution Permitted – NO STAMPS** **Date**

_____

Print Name of Healthcare Provider

ePrescribe ID #3306986 If you choose to ePrescribe directly to CareMed Pharmacy you are certifying that you have received patient consent for CareMed and eucrisa•4•you to contact your patient and provide them services. CareMed Specialty Pharmacy is categorized as a Mail Order pharmacy in EMR/EHR systems and is located at 1981 Marcus Ave., Suite 225, Lake Success, NY 11042.

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7. PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing this form, I agree to communications from Pfizer, eucrisa•4•you Personalized Support, 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 copay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer, eucrisa•4•you Personalized Support, 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, eucrisa•4•you Personalized Support, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, eucrisa•4•you Personalized Support, 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 eucrisa•4•you Personalized Support at 1-844-EUCRISA.

☐ By checking this box and providing my cellular phone number below, I consent to receive enrollment status, shipping updates, and refill reminders from eucrisa•4•you Personalized Support via text message. I will receive a welcome text asking me to reply YES to opt in. Message and data rates may apply; number of messages varies based on program use, but is up to 10 texts per month. Reply STOP to cancel. Privacy policy and full Terms available at https://engagedmedia.com/42762/privacypolicy.php.

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

X _____
Print Name of Patient

X _____
Patient/Caregiver Signature Date

8. HEALTHCARE PROVIDER HIPAA AND TCPA ATTESTATION

By my signature, I certify that 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 Pfizer and its employees or agents for purposes relating to Pfizer's patient support programs, including assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as copay support or free drug programs, for which the patient may be eligible, and other support for EUCRISA.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, eucrisa•4•you Personalized Patient Support, and/or parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Pfizer, eucrisa•4•you Personalized Patient Support, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

X _____
Signature of Healthcare Provider Date

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HIPAA Authorization Form for the Disclosure of Patient Information by Personal Physician

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other health care providers ("Health Care 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 prior authorization requirements from my insurer
  - Assistance with appealing any denial from my insurer
- Determining my eligibility for and helping me access copay support or free drug programs
- Communicating with my Health Care 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 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 Health Care Providers or payment from my health insurer. However, if I do not sign this form, eucrisa•4•you Personalized Support 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. However, Pfizer agrees to protect my health information and to use it 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 eucrisa•4•you Personalized Support at 1981 Marcus Ave., Suite 225, Lake Success, NY 11042, 1-844-EUCRISA. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

I also give my permission to receive communications from Pfizer, eucrisa•4•you Personalized Support, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as copay support or free drug programs, and for other non-marketing purposes. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, eucrisa•4•you Personalized Support, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, eucrisa•4•you Personalized Support, 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 eucrisa•4•you Personalized Support at 1-844-EUCRISA.

x _____

Signature of Patient/Caregiver Date

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PLEASE PROVIDE THIS PAGE TO THE PATIENT DURING THEIR VISIT

Your doctor has sent your prescription(s) to eucrisa•4•you Personalized Support to help you with your access to EUCRISA

PLEASE CALL 1-844-EUCRISA (1-844-382-7472) TODAY TO DISCUSS HOW THE EUCRISA•4•YOU PERSONALIZED SUPPORT PROGRAM MAY BE ABLE TO HELP

eucrisa•4•you Personalized Support is operated by CareMed Pharmacy and will work with you to determine if you have coverage for EUCRISA through your insurance. They will also work with you to fill your prescription.

What to Expect:

If you can't call after leaving your doctor's office, expect a call from CareMed Pharmacy when your prescription is received. The number will be displayed as 1-844-382-7472 on your caller ID. Topics discussed during the call may include:

- Requests for missing information
- Insurance coverage status updates

Once coverage through your insurance plan has been completed, your medication will be delivered to you or transferred to a pharmacy of your choice. CareMed Pharmacy will call to:

- Confirm where your prescription should be sent
- Request shipping preferences for your medication (if your prescription is filled by CareMed)
- Provide refill reminders (if your prescription is filled by CareMed)

Patient Eligibility Requirements*

Patients with a valid prescription for EUCRISA who consent to eucrisa•4•you Personalized Support operated by CareMed Pharmacy and are not otherwise excluded from the Program are eligible to receive services. Patients residing where the services under the Program are prohibited by law, as determined by either party, are not eligible for the Program.

*By using this service, you acknowledge that your doctor has advised you that you are free to choose another pharmacy to fill your prescription.

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