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GAUCHER PERSONAL SUPPORT® ENROLLMENT FORM

HOW TO COMPLETE

✔ **All pages of this form must be completed and sent to Gaucher Personal Support Program. The Special Instructions box is optional per the available selection below.**

SPECIAL INSTRUCTIONS:

- **Benefit Verification ONLY:** The Gaucher Personal Support (GPS) Case Manager can investigate insurance coverage for patients and will reach out to review and help them understand coverage options.

✔ **Please be sure to include Site of Care Information.**

✔ **Have the patient review and sign pages 1 and 2 and send to the Gaucher Personal Support Program.**

ELELYSO Copay Program*: Eligible, commercially insured patients may pay as little as $0 per month and assistance may be up to a maximum of $15,000 per calendar year.

*Eligibility required. Eligible patients may pay as little as $0 per month and assistance may be up to a maximum of $15,000 per calendar year. State and federal health care program beneficiaries not eligible even if they elect to be processed as an uninsured (cash-paying) patient. Terms and conditions apply. The savings program is not health insurance. No membership fees. Pfizer reserves the right to rescind, revoke or amend this offer without notice. Offer expires 12/31/2023. For more information, visit our website at www.elelyso.com, call 1-855-353-5976, or visit Pfizer.com. ELELYSO Copay Program, 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067. Click here for terms and conditions.

Fax completed forms to Gaucher Personal Support at 1-866-758-7135

OR

Mail to Gaucher Personal Support: 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067

You may access additional forms at www.elelysohcp.com

By enrolling in Gaucher Personal Support Program, patients will receive various support and information to help access ELELYSO, which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Providing benefits verification and reimbursement support, including:
  - Assisting with identification of the patient's insurer's prior authorization requirements
  - Assisting with identification of the patient's insurer's requirements for appealing a denied claim
- Determining eligibility for and helping eligible patients access copay support or free drug programs
- Communicating with the patient's Healthcare Providers about ELELYSO and Patient Support Activities
- Providing the patient with financial assistance resources and information, if eligible
- Providing the patient with disease management and other educational materials, as well as information about Pfizer's products, services, and programs, and may include sending the patient surveys about their experience with Pfizer products, services, and programs

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

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GAUCHER PERSONAL SUPPORT® ENROLLMENT FORM

Please complete and fax this form to **1-866-758-7135.** For assistance or additional information, call **1-855-ELELYSO (1-855-353-5976),** Monday–Friday, 9 AM - 6 PM ET

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SPECIAL INSTRUCTIONS

☐ Benefits Verification ONLY

1 PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

DOB (mm/dd/yyyy) _____ Weight (kg) _____ Gender M F Parent/Guardian Name _____

Address _____ City _____ State _____ ZIP Code _____

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

Email _____ Preferred Language (if not English) _____

Caregiver Name _____ Caregiver Phone _____ H W M

Caregiver Email _____

2 INSURANCE INFORMATION

☐ **INSURANCE CARD(S) ATTACHED** **CHECK IF PATIENT DOES NOT HAVE PRESCRIPTION COVERAGE** ☐ **CHECK IF PATIENT HAS SECONDARY PRESCRIPTION COVERAGE**

Primary Insurance _____ Insurance Phone _____

Policy ID # _____ Group # _____

Policy Holder First Name _____ Policy Holder Last Name _____

Policy Holder DOB (mm/dd/yyyy) _____ Policy Holder Relationship to Patient _____

Prescription Drug Insurer _____ Phone _____

Policy ID # _____ Group # _____

Rx BIN # _____ Rx PCN # _____

Patient's Preferred Pharmacy _____ ☐ 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.

3 PATIENT CONSENT TO RECEIVE COMMUNICATIONS

By signing this form, I agree to communications from Pfizer, Gaucher Personal Support, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, financial assistance resources, information and other Patient Support Activities (such as copay support or free drug programs) and for other non-marketing purposes. I agree to be contacted by Pfizer, Gaucher Personal 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, Gaucher Personal Support, and/or parties acting on their behalf for the purposes described above, and hereby gives his or her permission for Pfizer, Gaucher Personal Support, and/or parties acting on their behalf to contact him or her for such purposes at the phone number(s) provided.

I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Gaucher Personal Support at 1-855-ELELYSO (1-855-353-5976).

SIGN _____ _____ _____

Patient Signature | Print Name of Patient | Date

SIGN _____ _____ _____

Patient Representative Signature | Print Name of Patient Representative | Date

(Required if you have a Patient Representative who will be communicating with Pfizer Gaucher Personal Support)

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 _____

PLEASE COMPLETE AND FAX THIS FORM, ALONG WITH A COVER SHEET, TO 1-866-758-7135 OR MAIL TO 2730 S. EDMONDS LANE, SUITE 300, LEWISVILLE, TX 75067

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PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

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.

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 (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 copay 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 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 Healthcare Providers or payment from my health insurer. However, if I do not sign this form, Gaucher Personal 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. 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 Gaucher Personal Support at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, or at 1-855-ELELYSO (1-855-353-5976). 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.

SIGN _____ _____ _____

Patient Signature | Print Name of Patient | Date

SIGN _____ _____ _____

Patient Representative Signature | Print Name of Patient Representative | Date

(Required if you have a Patient Representative who will be communicating with Pfizer Gaucher Personal Support)

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 _____

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Patient Full Name _____ Patient DOB (mm/dd/yyyy) _____

4 SITE OF CARE INFORMATION

Based on patient preference and as allowed by the payer. Some exclusions may apply.

Infusion Administration ☐ Medical Facility ☐ Home Infusion ☐ Other

Name (First, Last) _____ Office Contact _____

National Provider ID # _____ Site Name _____

Address _____ City _____ State _____ ZIP Code _____

Phone _____ Fax _____

Administering physician's UPIN or Provider ID # with patient's insurer(s) _____

Special Instructions _____

5 PRESCRIBER INFORMATION *REQUIRED FIELD

*Prescriber First Name _____ *Prescriber Last Name _____ Prescriber NPI # _____

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

*Practice Name _____ Office Contact _____

*Address _____ *City _____ *State _____ *ZIP Code _____

*Phone _____ Fax _____

6 DIAGNOSIS

Type 1 Gaucher

7 ELELYSO PRESCRIPTION

Provide any medical/ancillary supplies, including syringe and needles, as necessary to administer prescribed medications.

_____ units IV every _____ weeks quantity _____ Refills _____ months

Dose 60 Units/kg (supplied as 200-unit vials for reconstitution). Reconstitute each vial with 5.1 mL of Sterile Water for Injection. Mix vials gently. Dilute with 0.9% Sodium Chloride Injection, USP, to a final volume of _____ mL. (Please note: For **pediatric patients,** a final volume of 100 to 120 mL should be used. For **adult patients,** a final volume of 130 to 150 mL may be used. However, if the volume of the reconstituted product alone is equal to or greater than 130 to 150 mL, then the final volume should not exceed 200 mL.)

☐ **0.9% Sodium Chloride Injection, USP, for dilution**

Premedication Orders
(Please specify drug, dose, route, and timing of administration for each below.)

Antihistamine _____

Corticosteroid _____

Other _____

8 IV ACCESS AND CATHETER FLUSH INSTRUCTIONS

Access Type ☐ Central line/port ☐ Peripheral IV

☐ 0.9% Saline Flush – flush line/port with _____ mL for patency

Heparin Flush – flush port with _____ mL of Heparin _____ units/mL Disp # _____

Refills _____ x 1 yr

Port Occlusion _____ mg/mL as directed. Pharmacy authorized to dispense if home health nurse has confirmed port occlusion.

9 HEALTHCARE PROVIDER

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.

☐ I also give my permission to receive calls related to these services from Pfizer, Gaucher Personal Support, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

SIGN _____ _____

Doctor/Prescriber Signature: NO STAMPS **(Dispense as Written)** Date