PRESCRIBING AND ENROLLMENT FORM

TO BE COMPLETED BY **PRESCRIBER**

YOUR SOURCE™

Oxbryta® (voxelotor) 500mg Tablets
Oxbryta® (voxelotor) 300mg Tablets
Oxbryta® (voxelotor) 300mg Tablets for Oral Suspension

Fax to: (888) 418-4178
Phone: (833) 428-4968, Option 1
680 Century Point, Lake Mary, FL 32746

To prevent delays, prescribers are required to complete **page 1 AND page 2 (prescription page)**. Complete **ALL** fields and fax this form to (888) 418-4178 or call the number above for additional assistance.

YourSource offers the following services for patients prescribed Oxbryta® (voxelotor): Benefit Investigation, Prior Authorization Assistance, Appeal Assistance, Financial Assistance for Eligible Patients,* and Nurse Support. YourSource does not provide medical advice or case-management services. Patients should always talk with their healthcare provider if they need guidance about their specific condition or overall health. For more details on the services available to your patients, please visit YourSourceSupport.com.

STEP 1: PATIENT INFORMATION (PLEASE COMPLETE ALL FIELDS)

Patient First Name _____ Middle Initial _____ Last Name _____

Address _____ Apt # _____

City _____ State _____ ZIP _____

DOB (mm/dd/yyyy) _____ Gender ☐ Male ☐ Female ★ **Patient Weight:** _____ kg ★ Weight is required for prescription

Patient Cell Phone # _____ **Patient Home Phone #** _____

Patient Alternative Phone # _____ Patient Email Address _____

Permission to leave voice message for patient? ☐ Yes ☐ No Patient Preferred Language ☐ English ☐ Spanish ☐ Other _____

Authorized Caregiver(s)† (DO NOT OMIT; PLEASE COMPLETE)

Name of Authorized Caregiver _____ Relationship to Patient _____ Authorized Caregiver Phone # _____ Authorized Caregiver Email Address _____

Name of Authorized Caregiver #2 (if applicable) _____ Relationship to Patient _____ Authorized Caregiver #2 Phone # _____ Authorized Caregiver #2 Email Address _____

Permission to leave voice message with Authorized Caregiver(s) on behalf of patient? ☐ Yes ☐ No

†An Authorized Caregiver is someone who is legally authorized to make decisions on behalf of the patient.

STEP 2: INSURANCE INFORMATION

Has the patient started therapy? ☐ Yes ☐ No Is the patient insured? ☐ Yes ☐ No Insurance type: ☐ Commercial ☐ Medicare Part D ☐ Medicaid ☐ Other _____

Complete **ALL** the information below. If available, also fax a copy of front and back of patient's medical and prescription benefit insurance cards.

	Primary Medical Insurance	Primary Prescription Insurance	Secondary Prescription Insurance
Insurance Name			
Phone #			
Policy ID #			
Group #			
Policyholder Name			
Policyholder DOB (mm/dd/yyyy)			
Relationship to Patient			

STEP 3: PRESCRIBER INFORMATION

Prescriber First Name _____ Last Name _____ MD Specialty _____

Practice Information

Office/Clinic/Institution Name _____

Address _____ Suite # _____

City _____ State _____ ZIP _____

Office Phone # _____ Office Fax # _____

MD NPI # _____ Tax ID # _____

Office Contact Name _____ Office Contact Title _____

Office Contact Phone # _____ Office Contact Email _____

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STEP 4: DIAGNOSIS AND CLINICAL INFORMATION (COMPLETE ALL FIELDS)

★ REQUIRED FOR PRESCRIPTION

Patient Name _____ **Patient DOB** _____

Patient Address (Street, Apt #, City, State, ZIP)

_____

_____

★ **Primary ICD-10 Diagnosis:** ☐ **D57**

☐ **Other:** _____

List Concurrent Therapies/Medications _____

☐ **I attest I am aware of drug-drug interaction potential**

Drug and Nondrug Allergies _____

☐ **No known drug allergies**

STEP 5: PRESCRIPTION INFORMATION (COMPLETE ONLY ONE SECTION)

Product	Directions (SIG) & Quantity	Refills
Oxbryta® (voxelotor) 500mg Tablets	☐ SIG: Take 3 tablets, by mouth, once daily; Dispense Quantity: #90	☐ As needed for 1 year
	☐ Other: _____	☐ Zero refills
		☐ Other: _____
Oxbryta® (voxelotor) 300mg Tablets	☐ SIG: Take 2 tablets **(600mg)**, by mouth, once daily; Dispense Quantity: #60	☐ As needed for 1 year
	☐ SIG: Take 3 tablets **(900mg)**, by mouth, once daily; Dispense Quantity: #90	☐ Zero refills
	☐ Other: _____	☐ Other: _____
Oxbryta® (voxelotor) 300mg Tablets for Oral Suspension	☐ SIG: Prepare dose, 2 tablets **(600mg)**, as directed and take by mouth once daily; Dispense Quantity: #60	☐ As needed for 1 year
	☐ SIG: Prepare dose, 3 tablets **(900mg)**, as directed and take by mouth once daily; Dispense Quantity: #90	☐ Zero refills
	☐ Other: _____	☐ Other: _____

☐ **I will submit e-prescription directly to specialty pharmacy**
Please provide a compliant prescription if this section does not comply with your state's prescription laws. New York State Prescribers, please submit an e-script or Official New York Serialized Prescription with this enrollment form. Iowa Prescribers, please submit an e-script with this enrollment form.

STEP 6: PHYSICIAN CERTIFICATION AND SIGNATURE (NAME AND SIGNATURE REQUIRED)

SIGN HERE FOR PRESCRIBER

Print Prescriber Name _____ **Date** _____

Prescriber Address _____ **Prescriber Phone #** _____

Prescriber Signature _____
("Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute)

Prescriber Signature _____
(May Substitute / Product Selection Permitted / Substitution Permissible)

CA, MA, NC, & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____

ATTN: New York and Iowa Providers, please submit electronic prescription

(PRESCRIBER MUST MANUALLY SIGN. Rubber stamps, signature by other office personnel for the Prescriber, and computer-generated signatures will not be accepted.)

By signing above, I, as the prescribing physician, 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. 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 OXBRYTA. I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, Your**Source**, 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 nonmarketing purposes. I also give my permission to receive calls related to these services from Pfizer, Your**Source**, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

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PP-LTV-USA-0018

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

TO BE COMPLETED BY **PATIENT**

YOUR SOURCE™

Oxbryta® (voxelotor) 500mg Tablets
Oxbryta® (voxelotor) 300mg Tablets
Oxbryta® (voxelotor) 300mg Tablets for Oral Suspension

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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, depending on your program (collectively, "Patient Support Activities"):

- Providing benefits investigations 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, support for continuing on therapy, 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 Healthcare Providers or payment from my health insurer. However, if I do not sign this form, Your**Source** 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 Your**Source** at (833) 428-4968 or 680 Century Point, Lake Mary, FL 32746. 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, Your**Source**, and parties acting on their behalf, including text message, email, a live operator, 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 nonmarketing purposes. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Your**Source**, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Your**Source**, 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 Your**Source** at (833) 428-4968.

Patient Signature (patient or patient representative) _____ Patient or Patient Representative Name (please print) _____ Date _____

Patient Address _____ Phone Number _____ Patient Date of Birth _____

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

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

Read entire form, complete ALL form fields, then fax all pages to (888) 418-4178.

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PP-LTV-USA-0018

PATIENT AUTHORIZATION TO RECEIVE COMMUNICATIONS

TO BE COMPLETED BY **PATIENT**

YOUR SOURCE™

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Oxbryta® (voxelotor) 300mg Tablets for Oral Suspension

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680 Century Point, Lake Mary, FL 32746

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By signing this form, I agree to communications from Pfizer, Your**Source**, 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 nonmarketing purposes. I agree to be contacted by Pfizer, Your**Source**, or parties working on their behalf for these purposes at the telephone number(s) provided. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Your**Source**, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Your**Source**, 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 Your**Source** at (833) 428-4968.

☐ Your**Source**: By checking this box and providing my cellular number, I consent to receive autodialed nonmarketing texts from Pfizer and its service providers regarding enrollment status, prescription updates, and refill reminders from Your**Source** at the phone number provided. I may receive a welcome text asking me to reply YES to opt in. Up to 10 messages/month. Message and data rates may apply. Complete terms can be found at https://www.enrollsource.com/pfe and Pfizer's privacy policy at www.pfizer.com/privacy. Text STOP to opt out.

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

Patient Signature (patient or patient representative) | Patient or Patient Representative Name (please print) | Date

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

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

ACCESS NAVIGATOR OPT IN

When you enroll in Your**Source**, you have the option to be contacted by a Pfizer Access Navigator who can help you understand your insurance benefits and navigate the process to access your OXBRYTA therapy. Access Navigators are field-based employees of Pfizer and, if you choose, will help answer questions you may have about accessing the medication prescribed by your physician. Access Navigators are very familiar with access and reimbursement requirements for OXBRYTA, and the Access Navigator assigned to you will coordinate with Your**Source** and you on your journey to starting therapy (although you will still need to contact Your**Source** directly if you are seeking financial assistance). Working with an Access Navigator is optional. Even if you choose not to opt in for this support, you may still access all patient support programs you are eligible for by working with a Case Manager at Your**Source**.

☐ By checking this box, I request Access Navigator support and agree to receive telephonic communications from the Access Navigator assigned to my case as described above. I understand that my consent is not required or a condition for purchasing any Pfizer goods or services. I understand that I can opt out of support from, and communications with, the Access Navigator at any time by contacting Your**Source** at (833) 428-4968.

Patient Signature (patient or patient representative) | Patient or Patient Representative Name (please print) | Date

Patient Address | Phone Number | Patient Date of Birth

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

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

Scan/click to learn more about receiving updates and ongoing support with our Text Support Program.

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PFIZER PATIENT ASSISTANCE PROGRAM* APPLICATION (OPTIONAL)

TO BE COMPLETED BY **PATIENT**

YOUR SOURCE™

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For eligible patients prescribed Oxbryta who are uninsured or functionally uninsured

★ **REQUIRED FOR COMPLETION**

Please complete and sign to determine eligibility:

★ Total number of people within household (including applicant): _____

★ Total annual income for entire household: $_____

★ Are you a resident of the U.S. or a U.S. Territory? ☐ Yes ☐ No

★ Are you currently insured? ☐ Yes ☐ No

★ Are you enrolled in a Medicaid, Medicare, VA, Dept. of Defense, TRICARE, or any other state- or federally funded health insurance plan? ☐ Yes ☐ No
(Include copy of insurance and prescription cards.)

★ Have you been denied insurance coverage for Oxbryta? ☐ Yes ☐ No ☐ Not Known
(Include copy of appeal and denial letters, if available.)

★ Medicare Part D Address _____

★ My provider or pharmacy has reviewed my insurer-required copayment with me, and I certify that I am unable to afford this medicine. ☐ Yes ☐ No

PATIENT AUTHORIZATION FOR ELECTRONIC INCOME VERIFICATION

Optional, but may reduce application review time. If Form isn't signed, income documentation is REQUIRED.

By signing below, I, the applicant named above, understand that I am providing "written instructions" to Pfizer Inc. under the Fair Credit Reporting Act, authorizing Pfizer Inc. to obtain information from my credit profile or other information from Experian® Income View℠. I authorize Pfizer Inc. to obtain such information solely for the purpose of determining financial qualifications for the Pfizer Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Pfizer Patient Assistance Program financial screening process. I understand that I am entitled to a copy of this Authorization upon request. This Authorization shall be valid for two (2) years from the date of the signature of this form (unless a shorter period is prescribed by law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to 680 Century Point, Lake Mary, FL 32746, but that this cancellation will not apply to any information already used or disclosed through this Authorization. Patient Authorization for Financial Screening: My signature certifies that I have read and understand the above statements, and agree to the outlined terms.

Patient Signature (patient or patient representative) _____ Patient or Patient Representative Name (please print) _____ Date _____

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

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

PFIZER PATIENT ASSISTANCE PROGRAM PATIENT AUTHORIZATION

The information you provide will be used by Pfizer, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve the Pfizer Patient Assistance Program, to communicate with you about your experience with the Pfizer Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

Patient Declaration: By signing below, 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. I understand that: Completing this enrollment form does not guarantee that I will qualify for the Pfizer Patient Assistance Program. Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by the Pfizer Patient Assistance Program shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel the Pfizer Patient Assistance Program, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I am enrolled in a Medicare Part D Plan and am eligible for the Pfizer Patient Assistance Program, Pfizer will notify my Part D Plan of my enrollment in the Pfizer Patient Assistance Program. If I am a new commercially insured patient applying after January 1, 2024, I cannot receive assistance through the Pfizer Patient Assistance Program. I certify and attest that if I receive medicine(s) provided by Pfizer through the Pfizer Patient Assistance Program: I will promptly contact the Pfizer Patient Assistance 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 true out-of-pocket (TrOOP) costs for prescription drugs. I will not submit claims, seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payor, 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 a signed copy of a current and completed Patient Authorization to Share Health Information Form on record with my Prescriber so that my Prescriber may share health information about me with the Pfizer Patient Assistance Program, Pfizer Inc., and the Pfizer Patient Assistance Foundation™ Inc.

Patient Signature (patient or patient representative) _____ Patient or Patient Representative Name (please print) _____ Date _____

Patient Address _____ Phone Number _____ Patient Date of Birth _____

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

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