



HCPs can go to PfizerDermatologyHCPPortal.com to complete this form online.
Questions? Call 1-833-956-3376, Monday - Friday, 8:00 AM to 8:00 PM ET.

 HCPs can upload online at PfizerDermatologyHCPPortal.com

 Fax completed forms to 1-877-548-1734

 HCPs can e-Prescribe directly to Sonexus Health Pharmacy Services*

SELECT PATIENT PRESCRIPTION (*Select ONE MEDICATION per enrollment form)		
CIBINQO® (abrocitinib) tablets <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg	EUCRISA® (crisaborole) ointment, 2% <input type="checkbox"/> 60-g tube <input type="checkbox"/> 100-g tube	LITFULO™ (ritlecitinib) capsules <input type="checkbox"/> 50 mg

FOR PATIENTS – Complete the following sections; then, read, sign, and date (where applicable) the required authorization and consents on pages 2 and 3. Missing information or consents may cause delays in filling your prescription and signing you up for the Pfizer Dermatology Patient Access™ support program.

1. PATIENT INFORMATION (*REQUIRED)

First Name* _____ MI _____ Last Name* _____

DOB* (mm/dd/yyyy) _____ Gender M F Other

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

Primary Phone* _____ H W M

Best time to reach me: Morning Afternoon Evening

Email _____

Preferred Language (if not English) _____

Caregiver Name _____ Phone _____
(Required if patient is under 18)

2. INSURANCE INFORMATION - Insurance Type : Commercial Government Medicare Part D Other None **(*REQUIRED)**

	Primary Medical Insurance*	Primary Prescription Insurance*	Secondary Prescription Insurance
	(*REQUIRED only if front and back copies of insurance card[s] are NOT provided)		
Policyholder Name*			
Insurance Name*			
Insurance Phone*			
Policy ID #*			
Group #*			
BIN #*			
PCN #*			

*If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying that you have received patient consent for Sonexus Health Pharmacy Services and Pfizer Dermatology Patient Access™ to contact your patient and provide them services. Sonexus Health Pharmacy Services is categorized as a mail-order pharmacy in EMR/EHR systems and is located at 2730 S. Edmonds Lane, Suite 400, Lewisville, TX 75067.

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.

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3A. 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 Dermatology Patient Access™ at 1-833-956-DERM (1-833-956-3376). 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 1-833-956-3376, 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.

3B. 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 Dermatology Patient Access™, 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.

Consent to Receive Emails (Optional)

By providing my email address in Section 1 or below, I consent to receive program information, enrollment status, shipping updates, and refill reminders from Pfizer Dermatology Patient Access™ via email. Email will be one-way communication identified as Pfizer Dermatology Patient Access™ from a "Do Not Reply" email box. I can opt out of these emails anytime by contacting Pfizer Dermatology Patient Access™ at 1-833-956-DERM (1-833-956-3376).

Email address: _____

I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer Dermatology Patient Access™ at 1-833-956-DERM (1-833-956-3376). 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 Engagedrx.com/PDPA and Pfizer's privacy policy at www.pfizer.com/privacy. Text STOP to opt out.


3C. PATIENT ACCESS COORDINATOR (PAC) OPT-IN

When you enroll in Pfizer Dermatology Patient Access™, you have the option to be contacted by a Pfizer Patient Access Coordinator (PAC), who can help you understand your insurance benefits and navigate the process to access your prescribed medication. PACs 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. PACs are very familiar with access and reimbursement requirements for CIBINQO® (abrocitinib) and LITFULO™ (ritlecitinib), and the PAC assigned to you will coordinate with Pfizer Dermatology Patient Access™ and you on your journey to starting therapy (although you will still need to contact Pfizer Dermatology Patient Access™ directly if you are seeking financial assistance). Working with a PAC 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 patient support representative at Pfizer Dermatology Patient Access™.

By checking this box, I request PAC support and agree to receive telephonic communications from the PAC 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 PAC at any time by contacting Pfizer Dermatology Patient Access™ at 1-833-956-DERM (1-833-956-3376).

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CHECK IF APPLICABLE BENEFITS INVESTIGATION ONLY

This prescription has also been sent to a Specialty Pharmacy Provider (SPP)

SPP Name _____ SPP Phone Number _____

Patient First Name* _____ Last Name* _____ Date of Birth (mm/dd/yyyy)* _____ **(*REQUIRED)**

FOR HEALTHCARE PROFESSIONALS – Complete the following sections and sign this page. Fax COMPLETED form with a cover sheet to 1-877-548-1734.

4. PRESCRIBER INFORMATION **(*REQUIRED)**

First Name* _____ Last Name* _____

NPI#* _____ State License Number* _____

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

Office Contact Name _____ Office Phone Number* _____ Ext. _____

Office Fax* _____ Email _____

5. DIAGNOSIS **(*REQUIRED)** – DO NOT ATTACH ANY CLINICAL OR OFFICE NOTES AS THIS MAY DELAY PROCESSING THE FORM

ICD-10 codes for CIBINQO and EUCRISA:

- L20: Atopic Dermatitis
- L20.8: Other Atopic Dermatitis
- L20.9: Atopic Dermatitis, Unspecified

ICD-10 codes for LITFULO:

- L63: Alopecia Areata
- L63.0: Alopecia (Capitis) Totalis
- L63.1: Alopecia Universalis

- L63.2: Ophiasis
- L63.8: Other Alopecia Areata
- L63.9: Alopecia Areata, Unspecified
- Other _____

6. PRESCRIPTION INFORMATION – Directions for e-Prescribing are located in Section 7 **(*Select one medication per enrollment form)**

Interim Care Rx for CIBINQO and LITFULO: Only filled through Sonexus Health Pharmacy Services. By requesting this, you certify that you understand the terms and conditions on page 5.

Prescription for CIBINQO® (abrocitinib) tablets
(up to 30 days, 30 tablets)

- 50 mg PO once daily Refills _____
- 100 mg PO once daily Refills _____
- 200 mg PO once daily Refills _____

Interim Care Rx for CIBINQO (11 Refills):
(up to 30 days, 30 tablets)

- 50 mg PO once daily
- 100 mg PO once daily
- 200 mg PO once daily

Voucher Rx for CIBINQO:
(One-time 30-day supply)

- 50 mg PO once daily
- 100 mg PO once daily
- 200 mg PO once daily

Prescription for LITFULO™ (ritlecitinib) capsules
(up to 28 days, 28 capsules)

- 50 mg PO once daily Refills _____

Interim Care Rx for LITFULO (11 Refills):
(up to 28 days, 28 capsules)

- 50 mg PO once daily

Prescription for EUCRISA® (crisaborole) ointment, 2%

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

Directions for use (please include location on body)

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

Concomitant Medications: _____

7. Healthcare Provider **CERTIFICATION** **Prescriber Signature – NO STAMPS (*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 Program services from Pfizer, Pfizer Dermatology Patient Access™, and parties acting on their behalf.

SIGN 

Healthcare Provider Signature: **NO STAMPS**

Print Name of Healthcare Provider

Date*

*e-Prescribe ID (NCPDP: 5910206; NPI: 1447680210). If you choose to e-Prescribe directly to Sonexus Health Pharmacy Services, you are certifying that you have received patient consent for Sonexus Health Pharmacy Services and Pfizer Dermatology Patient Access™ to contact your patient and provide them services. Sonexus Health Pharmacy Services is categorized as a retail pharmacy in EMR/EHR systems and is located at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067.

If you are a prescriber based in New York state, please use a New York state prescription form.

CIBINQO® (abrocitinib) and LITFULO™ (ritlecitinib) Interim Care Rx Program: TERMS AND CONDITIONS

Interim Care is not health insurance and is available for eligible, commercially insured patients only. Offer is only available to patients who have been diagnosed with an FDA-approved indication for CIBINQO® (abrocitinib) or LITFULO™ (ritlecitinib). No claim for reimbursement for product dispensed pursuant to this offer may be submitted to any third-party payer. Not available to patients covered under Medicaid, Medicare or other federal or state healthcare programs, including any state prescription drug assistance programs and the Government Health Insurance Plan or for residents of Massachusetts, Michigan, Minnesota, or Rhode Island. Available up to a 30-day supply. Refills are subject to limitations. Interim Care offer does not require, nor will be made contingent on, purchase requirements of any kind. Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification. Interim Care can only be dispensed by the exclusive pharmacy and only after a benefits investigation has been completed and a delay occurs in the Prior Authorization process, or an appeal is required. Offer good only in the U.S. and Puerto Rico. Prescription must be provided by a healthcare provider licensed in the U.S. or Puerto Rico. Patients whose insurance plans have established a product exclusion for either CIBINQO or LITFULO are not eligible to participate and/or continue participation in the Interim Care Program. Continued eligibility for the program requires, 1. submission of first appeal within 60 days of enrollment (or within the required payer timeline, if sooner) in the Interim Care Program and submission of the second appeal, if allowed by the payer, within 60 days of the date of the first appeal denial (or within the required payer timeline, if sooner), 2. satisfying all payer appeal requirements and 3. patients schedule their initial prescription dispense within 60 days of enrollment. If at any time during the patient's Interim Care Program enrollment there is a payer coverage change relating to the applicable product, Pfizer may conduct a new benefits investigation, and, if allowed by the payer, submission of a new Prior Authorization request and an appeal, if denied, must be submitted within 60 days (or within the required payer timeline, if sooner) of either, 1. the date of completion of the benefits investigation, provided by the Pfizer Dermatology Patient Access™ Program to the patient's authorized healthcare provider, or 2. the date a new submission is allowed by the payer, for continued eligibility in the program, whichever is later. If there is no payer coverage change, at 12 months of Interim Care Program enrollment, an updated prescription and benefits investigation is required to confirm continued eligibility. All payer appeal timelines must be met for continued assistance. Assistance may be available for up to two years in total, which is the lifetime maximum per patient. The Interim Care Program is applicable to all CIBINQO® (abrocitinib) or LITFULO™ (ritlecitinib) formulations. Additional eligibility criteria may apply. Contact Pfizer Dermatology Patient Access™ at 1-833-956-DERM (1-833-956-3376) for details.

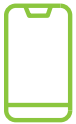
VOUCHER TERMS AND CONDITIONS FOR THE PATIENT

By redeeming this voucher, you acknowledge that you currently meet the eligibility criteria and will comply with the terms & conditions described below:

You will receive a one-time, 30-day trial supply of CIBINQO. Only new patients may use this voucher and each patient is limited to one voucher. By redeeming this voucher, you certify that you are not currently using CIBINQO. This voucher may not be transferred, sold, purchased, traded, or counterfeited. An original voucher and a valid prescription must be presented to the pharmacy. **The voucher will be accepted only at participating pharmacies. You must not submit any claim for reimbursement for product dispensed pursuant to this voucher to any third-party payor, including Medicare, Medicaid, or any other federal or state health care program. You cannot apply the value of the free product received through this voucher toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).** This voucher is not valid where prohibited by law. This voucher cannot be combined with any other external savings, free trial, or similar offer for the specified prescription. This voucher should not be combined with samples for the specified prescription. **This free trial voucher is not health insurance. This free trial voucher may not be used to address delays or gaps in health insurance coverage for the specified prescription.** Offer good only in the U.S. and Puerto Rico. No purchase is necessary. Patients have no obligation to continue to use CIBINQO. Pfizer reserves the right to rescind, revoke, or amend this offer without notice. This voucher expires 12/31/2026.

PLEASE PROVIDE THIS PAGE TO THE PATIENT DURING THEIR VISIT

Your doctor has sent your prescription(s) to Pfizer Dermatology Patient Access™ to help you with your access to CIBINQO® (abrocitinib), LITFULO™ (ritlecitinib), or EUCRISA® (crisaborole).



Please call 1-833-956-DERM (1-833-956-3376) today to discuss how Pfizer Dermatology Patient Access™ may be able to help



SCAN and save the Pfizer Dermatology Patient Access™ contact information to your phone.

Pfizer is not accessing data on the user's phone.

Pfizer Dermatology Patient Access™ will work with you to determine if you have coverage for CIBINQO, LITFULO, or EUCRISA through your insurance.

What to expect:

A Patient Support Representative from Pfizer Dermatology Patient Access™ will call you when your prescription is received. The number will be displayed as 1-833-956-3376 on your caller ID.

Topics discussed during the call may include:

- Requests for missing information
- Insurance coverage information
- Pharmacy preference

Once coverage through your insurance plan has been determined and approved, your medication will be either delivered to you by a specialty pharmacy or transferred to a pharmacy of your choice.

Please see full [Prescribing Information](#), including **BOXED WARNING**, and [Medication Guide](#) for CIBINQO®, and full [Prescribing Information](#), including **BOXED WARNING**, and [Medication Guide](#) for LITFULO™.