XELSOURCE℠
Answers and Support

PRESCRIPTION INFORMATION AND XELSOURCE ENROLLMENT FORM

Please complete and fax this form, along with a fax cover sheet, to 1-866-297-3471. For assistance or additional information, call 1-855-4-XELJANZ (1-855-493-5526), Monday–Friday, 8 am–8 pm ET

☐ **BENEFITS INVESTIGATION ONLY**
X_____ Date_____

Check and sign here if you are ONLY requesting a summary of your patient's benefits. For full services including prescription fulfillment please sign prescription below.

❶ Patient Information

Name (First, MI, Last)_____ DOB (mm/dd/yyyy)_____ Gender: ☐M ☐F

Address_____ City_____ State_____ ZIP Code_____

E-Mail_____ Primary Phone_____ ☐H ☐W ☐M Alternate Phone_____ ☐H ☐W ☐M

❷ Insurance Information

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

☐**CHECK IF PATIENT DOES NOT HAVE INSURANCE**

Primary Insurance_____ Insurance Phone_____ Policy ID #_____

Group #_____ Policy Holder Name (First, Last) and Relationship To Patient_____

Prescription Drug Insurer_____ Preferred Specialty Pharmacy_____

Policy ID #_____ Group #_____ Rx BIN #_____ Rx PCN #_____

❸ Patient Authorization

to enroll In XELSOURCE and use of Protected Health Information

Patient should read the Patient Authorization on the attached Patient Copy and sign below. My signature below certifies that I have read, understand and agree to the Patient Authorization to release my protected health information to Pfizer Inc, its affiliates, agents, representatives, and service providers (including but not limited to United BioSource LLC, its affiliates, and specialty pharmacies) to enroll me in XELSOURCE as described in the attached Patient Copy.

Patient Name_____ Date_____

X_____ Relationship_____
Signature: Patient/Person legally authorized to sign for patient

❹ Prescriber Information

Prescriber Name (First, Last)_____ Specialty_____

Practice Name_____ Office Contact_____

Address_____ City_____ State_____ ZIP Code_____

E-Mail_____ Phone_____ Fax_____

Prescriber NPI #_____ State License #_____ Medicaid/Medicare Provider #_____

❺ Clinical Information

Please attach any clinical or office notes relevant to therapy.

DIAGNOSIS: ☐**714.0 Rheumatoid Arthritis (RA)** ☐**714.2 Other RA with visceral or systemic involvement** ☐**Other**_____

Allergies_____

Date of Diagnosis or years with disease_____ TB/PPD Test Date_____ ☐POS ☐NEG Hep B Test Date_____(optional) ☐POS ☐NEG

Prior Failed RA Medication(s)	Treatment Length (mm/yyyy)	Reason for Discontinuation
☐Methotrexate	–	
	–	
	–	
	–	
	–	

❻ Prescription Information

Be sure to check the appropriate Rx, fill in # of refills, and sign. A separate signature is required to order a Free Trial.

By signing this form, I certify that therapy with XELJANZ® (tofacitinib citrate) 5 mg tablets is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current XELJANZ Prescribing Information. I have received the necessary authorization to release medical and/or other patient information relating to XELJANZ therapy to Pfizer Inc and its affiliates, agents, representatives, and service providers (including but not limited to United BioSource LLC, its affiliates, and specialty pharmacies) to use and disclose as necessary to enroll my patient in the XELSOURCE program. I further authorize XELSOURCE to forward the prescription below to a pharmacy for fulfillment, and (as applicable) to assess my patient's eligibility for patient assistance.

XELJANZ Rx 5 mg tablets

☐**Take 5 mg PO BID, Quantity #60 (30 days)**

☐**Other:** Directions_____ Quantity_____

REFILLS #:_____

Doctor/Prescriber Signature (NO STAMPS)

X_____
Dispense as Written Date

X_____
Substitution Permissible Date

AND/ OR

XELJANZ Free Trial Offer

Trial Rx* 5 mg PO BID (14 days, 28 tablets)

FOR COMMERCIALLY INSURED PATIENTS ONLY (not available for Medicare, Medicaid, or other federal or state healthcare programs)

Doctor/Prescriber Signature (NO STAMPS)

X_____
Dispense as Written Date

X_____
Substitution Permissible Date

If you are a New York prescriber, please use an original New York State prescription form.

* Trial Rx is a one-time-only offer for eligible, commercially insured patients being prescribed XELJANZ for its FDA-approved indication. Offer only available to patients that have a diagnosis code of 714.0 Rheumatoid Arthritis or 714.2 Other Rheumatoid Arthritis with visceral or systemic involvement. The free product provided under the Trial Rx Program offer is for commercially insured patients only and does not require, nor will be made contingent on, purchase requirements of any kind. Trial Rx can only be dispensed by the exclusive pharmacy retained for this program. Please see accompanying Program Terms and Conditions.

Please see Indication and Important Safety Information on page 2. Click here for full Prescribing Information, including BOXED WARNING and Medication Guide.

INDICATION

- XELJANZ® (tofacitinib citrate) is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to methotrexate. It may be used as monotherapy or in combination with methotrexate or other nonbiologic disease-modifying antirheumatic drugs (DMARDs).
- Limitations of Use: Use of XELJANZ in combination with biologic DMARDs or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS INFECTIONS AND MALIGNANCY

SERIOUS INFECTIONS

Patients treated with XELJANZ are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants, such as methotrexate or corticosteroids.

If a serious infection develops, interrupt XELJANZ until the infection is controlled.

Reported infections include:

- **Active tuberculosis, which may present with pulmonary or extrapulmonary disease. Patients should be tested for latent tuberculosis before XELJANZ use and during therapy. Treatment for latent infection should be initiated prior to XELJANZ use.**
- **Invasive fungal infections, including cryptococcosis and pneumocystosis. Patients with invasive fungal infections may present with disseminated, rather than localized, disease.**
- **Bacterial, viral, and other infections due to opportunistic pathogens.**

The risks and benefits of treatment with XELJANZ should be carefully considered prior to initiating therapy in patients with chronic or recurrent infection.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with XELJANZ, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy.

MALIGNANCIES

Lymphoma and other malignancies have been observed in patients treated with XELJANZ. Epstein Barr Virus–associated post-transplant lymphoproliferative disorder has been observed at an increased rate in renal transplant patients treated with XELJANZ and concomitant immunosuppressive medications.

SERIOUS INFECTIONS

The most common serious infections reported with XELJANZ included pneumonia, cellulitis, herpes zoster, and urinary tract infection. Avoid use of XELJANZ in patients with an active, serious infection, including localized infections. Consider the risks and benefits of treatment before initiating XELJANZ in patients:

- with chronic or recurrent infection;
- who have been exposed to tuberculosis (TB);
- with a history of a serious or an opportunistic infection;
- who have lived or traveled in areas of endemic TB or mycoses; or
- with underlying conditions that may predispose them to infection.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with XELJANZ. XELJANZ should be interrupted if a patient develops a serious infection, an opportunistic infection, or sepsis.

Tuberculosis

Evaluate and test patients for latent or active infection before administration of XELJANZ. Consider anti-TB therapy prior to administration of XELJANZ in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed, and for patients with a negative test for latent TB but who have risk factors for TB infection. Treat patients with latent TB with standard therapy before administering XELJANZ.

Viral Reactivation

Viral reactivation, including cases of herpes virus reactivation (eg, herpes zoster), was observed in clinical studies with XELJANZ. Screening for viral hepatitis should be performed in accordance with clinical guidelines before starting therapy with XELJANZ.

MALIGNANCY and LYMPHOPROLIFERATIVE DISORDERS

Consider the risks and benefits of XELJANZ treatment prior to initiating therapy in patients with a known malignancy other than a successfully treated non-melanoma skin cancer (NMSC) or when considering continuing XELJANZ in patients who develop a malignancy.

In the 7 controlled rheumatoid arthritis clinical studies, 11 solid cancers and 1 lymphoma were diagnosed in 3328 patients receiving XELJANZ with or without DMARD, compared to 0 solid cancers and 0 lymphomas in 809 patients in the placebo with or without DMARD group during the first 12 months of exposure. Lymphomas and solid cancers have also been observed in the long-term extension studies in rheumatoid arthritis patients treated with XELJANZ.

In Phase 2B controlled dose-ranging trials in *de-novo* renal transplant patients, all of whom received induction therapy with basiliximab, high-dose corticosteroids, and mycophenolic acid products, Epstein Barr Virus–associated post-transplant lymphoproliferative disorder was observed in 5 out of 218 patients treated with XELJANZ (2.3%) compared to 0 out of 111 patients treated with cyclosporine.

Non-Melanoma Skin Cancer

Non-melanoma skin cancers (NMSCs) have been reported in patients treated with XELJANZ. Periodic skin examination is recommended for patients who are at increased risk for skin cancer.

GASTROINTESTINAL PERFORATIONS

Gastrointestinal perforations have been reported in rheumatoid arthritis clinical trials, although the role of JAK inhibition is not known. This happens most often in people who also take nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, or methotrexate. XELJANZ should be used with caution in patients who may be at increased risk for gastrointestinal perforation (eg, patients with a history of diverticulitis).

LABORATORY ABNORMALITIES

Lymphocyte Abnormalities

Treatment with XELJANZ was associated with initial lymphocytosis at 1 month of exposure followed by a gradual decrease in mean lymphocyte counts of approximately 10% during 12 months of therapy. Counts less than 500 cells/mm^3 were associated with an increased incidence of treated and serious infections. Avoid initiation of XELJANZ treatment in patients with a count less than 500 cells/mm^3. In patients who develop a confirmed absolute lymphocyte count less than 500 cells/mm^3, treatment with XELJANZ is not recommended. Monitor lymphocyte counts at baseline and every 3 months thereafter.

Neutropenia

Treatment with XELJANZ was associated with an increased incidence of neutropenia (less than 2000 cells/mm^3) compared to placebo. Avoid initiation of XELJANZ treatment in patients with an ANC less than 1000 cells/mm^3. For patients who develop a persistent ANC of 500-1000 cells/mm^3, interrupt XELJANZ dosing until ANC is greater than or equal to 1000 cells/mm^3. In patients who develop an ANC less than 500 cells/mm^3, treatment with XELJANZ is not recommended. Monitor neutrophil counts at baseline and after 4-8 weeks of treatment and every 3 months thereafter.

Anemia

Avoid initiation of XELJANZ treatment in patients with a hemoglobin level less than 9 g/dL. Treatment with XELJANZ should be interrupted in patients who develop hemoglobin levels less than 8 g/dL or whose hemoglobin level drops greater than 2 g/dL on treatment. Monitor hemoglobin at baseline and after 4-8 weeks of treatment and every 3 months thereafter.

Liver Enzyme Elevations

Treatment with XELJANZ was associated with an increased incidence of liver enzyme elevation compared to placebo. Most of these abnormalities occurred in studies with background DMARD (primarily methotrexate) therapy.

Routine monitoring of liver tests and prompt investigation of the causes of liver enzyme elevations is recommended to identify potential cases of drug-induced liver injury. If drug-induced liver injury is suspected, the administration of XELJANZ should be interrupted until this diagnosis has been excluded.

Lipid Elevations

Treatment with XELJANZ was associated with increases in lipid parameters, including total cholesterol, low-density lipoprotein (LDL) cholesterol, and high-density lipoprotein (HDL) cholesterol. Maximum effects were generally observed within 6 weeks.

Assess lipid parameters approximately 4-8 weeks following initiation of XELJANZ therapy, and manage patients according to clinical guidelines for the management of hyperlipidemia.

VACCINATIONS

Avoid use of live vaccines concurrently with XELJANZ. Update immunizations in agreement with current immunization guidelines prior to initiating XELJANZ therapy.

HEPATIC IMPAIRMENT

Use of XELJANZ in patients with severe hepatic impairment is not recommended.

ADVERSE REACTIONS

The most common serious adverse reactions were serious infections. The most commonly reported adverse reactions during the first 3 months in controlled clinical trials with XELJANZ 5 mg twice daily and placebo, respectively, (occurring in greater than or equal to 2% of patients treated with XELJANZ with or without DMARDs) were upper respiratory tract infections (4.5%, 3.3%), headache (4.3%, 2.1%), diarrhea (4.0%, 2.3%), and nasopharyngitis (3.8%, 2.8%).

USE IN PREGNANCY

There are no adequate and well-controlled studies in pregnant women. XELJANZ should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Click here for full Prescribing Information, including BOXED WARNING and Medication Guide.

PATIENT COPY

PROVIDER INSTRUCTIONS

❶ **Have the patient read this form and sign the acknowledgement on the front of the Prescription Information and XELSOURCE Enrollment Form relating to the Patient Authorization and XELSOURCE Extended Services Enrollment Information.**

❷ **Provide the patient with this sheet and a copy of the front and back of the Prescription Information and XELSOURCE Enrollment Form which they have signed.**

❸ **Fax the Prescription Information and XELSOURCE Enrollment Form to XELSOURCE at 1-866-297-3471.**

PATIENT AUTHORIZATION (PA)

My signature on the front of the Prescription Information and XELSOURCE Enrollment Form confirms that:

1. Disclosure of Protected Health Information to Pfizer Inc for XELSOURCE

I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription, and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my protected health information, including but not limited to information and medical records related to my medical condition and treatment associated with my prescription for XELJANZ® (tofacitinib citrate); my health insurance coverage; and my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to Pfizer Inc and its affiliates, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers (including but not limited to United BioSource LLC, and its affiliates, and specialty pharmacies) supporting XELSOURCE and other Pfizer Inc patient assistance programs (together, "Pfizer Inc").

Specifically, I authorize Pfizer Inc to receive, use, and disclose my Protected Health Information in order to: (i) enroll me in XELSOURCE and contact me. and/or the person legally authorized to sign on my behalf, about XELSOURCE; (ii) provide me, and/or the person legally authorized to sign on my behalf, with educational materials, information, and services related to XELJANZ; (iii) verify, investigate, assist with, and coordinate my coverage for XELJANZ, including but not limited to communicating with my Insurer, specialty pharmacies, and others involved in processing my pharmacy claims to verify my coverage; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to XELJANZ.

2. Use of Protected Health Information to Provide Marketing Communications and Information Related to XELSOURCE

I authorize any specialty pharmacy that receives my prescription to use my Protected Health Information to provide me with marketing communications and information related to XELSOURCE, including providing certain adherence messages. I acknowledge that these specialty pharmacies may receive compensation from Pfizer Inc for their services and costs incurred in connection with providing such marketing communications and information.

I understand that my Protected Health Information will not be used or disclosed by Pfizer Inc for any purposes other than as described here, unless permitted or required by law, or unless information that specifically identifies me is removed.

I understand that Pfizer Inc will make every effort to keep my Protected Health Information private. Nonetheless, I understand that the disclosed Protected Health Information may be re-disclosed in accordance with law and may no longer be protected by the federal privacy standards. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. If my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed under these circumstances and provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Patient Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign this Authorization, or revoke my authorization later, I understand that this means I will not be able to participate in or receive assistance from XELSOURCE.

This Authorization will expire ten (10) years after the date it is signed on the front of the Prescription Information and XELSOURCE Enrollment Form.

I understand that I may cancel (revoke) this Authorization at any time by mailing a letter to XELSOURCE, 255 Technology Park, Lake Mary, FL 32746. I can also revoke my authorization by informing my Healthcare Providers and Insurers in writing that: (1) I do not want them to share any information with Pfizer Inc, but this will not affect Pfizer Inc's ability to use and disclose Protected Health Information that was already disclosed to it under this Authorization; and (2) I do not want to be provided with marketing information and communications. My authorization will also end if XELSOURCE is discontinued.

Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have disclosed to Pfizer Inc.

XELSOURCE EXTENDED SERVICES ENROLLMENT INFORMATION

By signing the front of the Prescription Information and XELSOURCE Enrollment Form, I agree to allow Pfizer Inc, or parties acting on its behalf, to send me materials and other helpful information on rheumatoid arthritis and XELJANZ, as well as related treatments, products, offers, and services. To support the extended services program, your name, address, and other information that you give us will be used by Pfizer Inc, the marketer of XELJANZ, and companies that work with Pfizer Inc, including vendors and other affiliates, to support the Program.

Pfizer Inc understands that your personal health information is private. Pfizer Inc will not share your information with anyone else except as stated above and as required by law. If you want to stop receiving this information from Pfizer Inc, you may ask us to remove you from our contact list by calling 1-855-4-XELJANZ (1-855-493-5526).

Please read the Indication and Important Safety Information for XELJANZ on page 2 and discuss any questions you have with your doctor.

XELSOURCE℠
Answers and Support

Trial Rx Terms & Conditions

- This is not health insurance and is a one-time-only offer for eligible, commercially insured patients.
- Offer is only available to patients that have a diagnosis code of 714.0 Rheumatoid Arthritis or 714.2 Other Rheumatoid Arthritis with visceral or systemic involvement.
- Patients who have already begun therapy with XELJANZ® (tofacitinib citrate) at the time of the request and patients under the age of Eighteen (18) years of age are ineligible for participation in the Program.
- No claim for reimbursement for product dispensed pursuant to this offer may be submitted to any third-party private payer.
- Not available to patients covered under government plans such as 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.
- Available in a 14-day supply of 5 mg tablets.
- This 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.
- Trial Rx can only be dispensed by the exclusive pharmacy and only after benefits investigation has been completed.
- Additional eligibility criteria may apply, contact XELSOURCE for details.

Disclaimer

Pfizer's service provider performing XELSOURCE support services provides patient insurance benefit verification as a service under contract for Pfizer Inc. XELSOURCE support services assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Many factors affect third-party reimbursement. Pfizer Inc and Pfizer's service provider performing the XELSOURCE support services make no representation or guarantee that insurance reimbursement or any other payment will be available. This information is provided as an information service only. While Pfizer's service provider performing XELSOURCE support services tries to provide correct information, it and Pfizer Inc make no representations or warranties, expressed or implied, as to the accuracy of the information. The support services administrator, or Pfizer Inc, or its employees or agents shall in no event be liable for any damages resulting from or relating to the services. Responsibility for the use of this service is agreed upon and accepted by all providers and other users of this information.

Pfizer Inc does not guarantee, and assumes no responsibility for, the quality, scope, or availability of the XELSOURCE support services including but not limited to reimbursement support services, patient education, and other support services. XELSOURCE support services are included within the cost of the product, and have no independent value to providers apart from the product.

Please see Indication and Important Safety Information on page 2. Click here for full Prescribing Information, including BOXED WARNING and Medication Guide.