Pfizer enCompass™ Enrollment Form for RETACRIT™ (epoetin alfa-epbx)

Please complete and fax this form to 1-844-482-4482 or mail to: Pfizer enCompass, PO Box 220040, Charlotte, NC 28222
For assistance or additional information, call: 1-844-722-6672, Monday–Friday, 9 AM–8 PM ET

For enrollment into the Pfizer Patient Assistance Program or Drug Replacement Program, complete the Pfizer Patient Assistance Program Application available at www.pfizerencompass.com or by calling Pfizer enCompass.

Please check the appropriate box(es) and complete the enrollment form

☐ Benefit verification and/or prior authorization support (Complete sections 1-6)
☐ Referral for Interim Assistance (Complete sections 1-6)

1. PATIENT INFORMATION
*INDICATES REQUIRED FIELDS

*NAME (FIRST, MIDDLE INITIAL, LAST)

*DATE OF BIRTH (MM/DD/YYYY) *GENDER ☐ MALE ☐ FEMALE

*ADDRESS

*CITY *STATE *ZIP CODE

*PRIMARY PHONE

PREFERRED LANGUAGE EMAIL

CAREGIVER NAME

CAREGIVER PHONE ☐ H ☐ W ☐ C

☐ My caregiver has consented to have Pfizer enCompass communicate directly with them on my behalf.

2. CLINICAL INFORMATION
*INDICATES REQUIRED FIELDS

*PRIMARY ICD-10-CM DIAGNOSIS CODE

SECONDARY ICD-10-CM DIAGNOSIS CODE

3. INSURANCE INFORMATION *INDICATES REQUIRED FIELDS
PLEASE PROVIDE COPIES OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD(S)

*PRIMARY INSURANCE NAME

*INSURANCE COMPANY PHONE

*POLICY ID # *GROUP #

*POLICYHOLDER NAME

*RELATIONSHIP TO PATIENT *DATE OF BIRTH (MM/DD/YYYY)

SECONDARY INSURANCE

INSURANCE COMPANY PHONE

POLICY ID # GROUP #

POLICYHOLDER NAME

RELATIONSHIP TO PATIENT DATE OF BIRTH (MM/DD/YYYY)

PREFERRED SPECIALTY PHARMACY

4. HEALTHCARE PROVIDER INFORMATION
*INDICATES REQUIRED FIELDS

*REFERRING PROVIDER NAME (FIRST, LAST)

SPECIALTY *NPI # STATE LICENSE #

*PRACTICE NAME *TAX ID #

*OFFICE CONTACT

*ADDRESS

*CITY *STATE *ZIP CODE

*PHONE FAX

EMAIL

TREATMENT SITE OF SERVICE ☐ PHYSICIAN OFFICE ☐ HOSPITAL OUTPATIENT ☐ DIALYSIS CENTER ☐ HOME INFUSION/ INFUSION CENTER

ADMINISTERING PROVIDER INFORMATION (IF DIFFERENT FROM REFERRING PROVIDER)
Administering provider administers and oversees the product injection/infusion

*ADMINISTERING PROVIDER NAME (FIRST, LAST)

SPECIALTY *NPI # STATE LICENSE #

*PRACTICE NAME *TAX ID #

*OFFICE CONTACT

*ADDRESS

*CITY *STATE *ZIP CODE

*PHONE *FAX

EMAIL

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*NAME (FIRST, MIDDLE INITIAL, LAST)

5. Healthcare Provider Consent

By signing this enrollment form, I certify that therapy with RETACRIT is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current RETACRIT prescribing information. I have received the necessary authorization to release medical and/or other patient information relating to RETACRIT therapy to Pfizer Inc and its agents, affiliates, representatives, and service providers to use and disclose as necessary to enroll my patient into Pfizer enCompass. I have informed my patient or their caregiver that I will provide his/her contact information to Pfizer enCompass, and I have received and obtained prior express consent from my patient or their caregiver for Pfizer enCompass to contact my patient or their caregiver by phone for the purpose of providing insurance benefit verification services and identifying prescription payment assistance for which they may be eligible, including through the use of an autodialer or prerecorded voice at the telephone number provided. I also give my permission to receive calls related to these services from Pfizer enCompass, Pfizer Inc, and parties calling on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided. Pfizer reserves the right to revise or terminate this program, in whole or in part, without notice at any time.

PRINT NAME OF HEALTHCARE PROVIDER | **SIGNATURE OF HEALTHCARE PROVIDER** | **DATE**

6. Patient Consent

I understand that the information I provided will be used by Pfizer enCompass, Pfizer, and/or parties acting on its behalf to determine my eligibility and provide benefit verification and payment assistance services. I agree to be contacted by Pfizer enCompass, Pfizer Inc, and parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number provided. I understand that I can opt-out of these communications at any time by contacting Pfizer enCompass at 1-844-722-6672. Pfizer reserves the right to change or cancel Pfizer's assistance programs, or terminate my enrollment, at any time.

PRINT PATIENT'S NAME | **SIGNATURE OF PATIENT** | **DATE**

If the patient is incapacitated (physically or mentally), obtain the following signatures below:

SIGNATURE OF PERSONAL REPRESENTATIVE | **DESCRIPTION OF AUTHORITY** | **DATE**

DISCLAIMER

Insurance verification is the ultimate responsibility of the provider. Benefit information provided by Pfizer enCompass is not a guarantee of insurance coverage or reimbursement. All benefit information is subject to the insured patient's plan at the time services are rendered. Under no circumstances shall Pfizer enCompass be held responsible or liable for payment of any claims, benefits, or cost. Any coding information obtained from Pfizer enCompass is provided for informational purposes only, is subject to change, and should not be construed as legal advice. Providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to the specific patient.