



## Patient Authorization Form for Somavert

**SOMAVERT**<sup>®</sup>  
(pegvisomant for injection)

The Pfizer Bridge Program needs to have, review, use, and share health information about you in order to help you in many ways:

- to give you reimbursement help including:
  - obtaining prior authorization from your insurer for you, when needed
  - appealing any denials from your insurer for you, when needed
- to see if you are eligible for the Support Care Program
- to send you a Starter Kit, if needed
- to send you drug through the Support Care Program
- to send your prescription information to your pharmacy so that they can send you the drug you need

So that we can provide these services to you, we are asking you to agree to let your health care providers, health plan, or health insurers release your health information (called “Protected Health Information” or “PHI”) to the Pfizer Bridge Program. We are also asking you to agree to allow the Pfizer Bridge Program and its agents to use and share your PHI. The PHI we need includes all medical records that have to do with your treatment, other information about your medical condition and how well you are able to manage your treatment plan, information about your insurance coverage, and identifying information about you (including your name, address, date of birth, and Social Security number). The PHI we need to use and share may include PHI that we already have or PHI that we receive in the future. The Pfizer Bridge Program will only use this PHI in the ways described in this Authorization Form or as otherwise permitted by law.

You do not have to sign this Authorization Form, and if you choose not to sign it, your ability to obtain treatment from your health care providers and your eligibility for benefits under your health plan will not be affected. However, if you do not sign this Authorization Form, the Pfizer Bridge Program may not be able to give you reimbursement help or even see if you are eligible for Support Care. Please look over this Authorization Form carefully. Call your health care provider’s office if you have any questions.

### **Authorization:**

I authorize my health care providers, health plans, and health insurers to use and share my PHI (as described above) and financial information with the Pfizer Bridge Program, my pharmacy, and with Pfizer and each of their agents, including their present or future reimbursement vendor and/or pharmacy or pharmacies supplying Support Care drug.

This PHI may be provided to the Pfizer Bridge Program and the other parties mentioned above by me, my health care providers, health plans, health insurers, or others who have my PHI.

Pfizer, its agents, and any of the other parties mentioned above may use my PHI, and may share it with any of the above parties, to:

- give me reimbursement help, including obtaining prior authorization or appealing denials for me;
- see if I qualify or am eligible for the Support Care Program;
- inform my pharmacy so that they can send drug to me;
- send me a Starter Kit and/or drug through the Support Care Program;
- assist in ensuring timely case resolution;
- identify and resolve any outstanding needs related to my case; and
- review and analyze the use of a Pfizer product as well as the management and administration of the Pfizer Bridge Program.



**Patient Authorization Form  
for Somavert (cont.)**



Pfizer, its agents, and any of the other parties mentioned above may also disclose my PHI to a successor-in-interest to any portion of Pfizer's (or its agents') business affecting the Pfizer Bridge Program or the drug with respect to which I am seeking assistance.

I understand that once my PHI is shared, reasonable efforts will be made to protect my PHI, but some recipients of my PHI may not be subject to a federal law, called the Health Insurance Portability and Accountability Act of 1996 (or "HIPAA"), which governs the use and sharing of my PHI. These recipients could redisclose my PHI without being subject to penalties under HIPAA.

I understand that this Authorization Form applies to PHI that may have been obtained and shared both before and after I signed this form. This authorization will be good until it expires or until I provide written notice to my health care provider and the Pfizer Bridge Program (by fax at 1-800-479-2562) that I would like to withdraw my approval to share my PHI. The withdrawal will take effect as soon as my health care provider and the Pfizer Bridge Program get my written notice. This withdrawal, however, will not have any effect on the use and sharing of my PHI that took place before the withdrawal by any group mentioned in this Authorization Form. This includes the Pfizer Bridge Program.

**Signature:**

I have read and understand the terms of this Authorization Form. I have had a chance to ask questions about the use and sharing of my PHI. Once I sign this Authorization Form, this authorization will be in effect until December 31, 2020, unless I withdraw it in writing to both my health care provider and the Pfizer Bridge Program. I understand that I am able to make changes to the information provided to the Pfizer Bridge Program and I agree to notify the program about any changes to my information including my address, telephone number, or insurance coverage.

By signing below, I agree to authorize the use and/or sharing of my PHI in the ways described in this Authorization Form.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

If the patient is a minor or is incapacitated and has a legal representative, obtain the following signature:

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Description of Authority

\_\_\_\_\_  
Date

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