Enroll your eligible patients in the BeneFIX® Trial Prescription Program.

To begin, please have each eligible patient 1) read the terms and conditions, 2) complete parts 1-4 of this enrollment form, and 3) sign the authorization form.
The remaining sections must be completed by a health care professional for a complimentary product in accordance with the Prescription Drug Marketing Act of 1987. This program is intended for new BeneFIX patients. All products will be sent by the Pfizer Program Administrator.

Fax this completed form, along with the prescription for BeneFIX and the patient authorization form, to **1.888.868.8660**. Fax must be sent from a health care provider's office, or mail required documents to the **BeneFIX Trial Prescription Program Administrator, MedVantx, PO Box 5736, Sioux Falls, SD 57117-5736.** Please allow 1 to 3 weeks after submission of forms for processing and delivery.

BeneFIX Trial Rx Terms and Conditions

OFFER TERMS: By enrolling in the BeneFIX Trial Prescription Program, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below: You are currently covered by a private (commercial) insurance plan. An original free trial offer and a valid prescription must be presented. No claim for reimbursement for BeneFIX dispensed pursuant to this free trial offer may be submitted to any third-party payor. Medicaid, Medicare, or any other federal or state health care program beneficiaries are not eligible for this offer (this includes any state prescription drug assistance programs and Government Health Insurance Plan, available in Puerto Rico, formerly known as "La Reforma de Salud"). The free trial offer is not valid for prescriptions that are eligible to be reimbursed by private insurance plans or health or pharmacy benefit programs that reimburse you for the entire cost of your prescription drugs. This free trial offer is not valid where otherwise prohibited by law. You may receive a 1-month supply up to 20,000 IU of factor. **The free trial offer cannot be combined with any other rebate/coupon, free trial, or similar offer for the prescribed prescription. The free trial offer will only be accepted by participating factor providers. This free trial offer is not health insurance.** Offer good only in the US and Puerto Rico. Only new patients may use this offer. By redeeming this offer, you certify that you are not currently using Pfizer Factor Product. Only 1 offer per person may be redeemed under this program. This offer is not transferable. Pfizer reserves the right to rescind, revoke, or amend this free trial offer without notice. Offer expires 1 month from enrollment date or when the maximum benefit up to 20,000 IU at no cost has been reached. No membership fees. For questions about the BeneFIX Trial Prescription Program, please call 1.844.989.HEMO (4366) or write us at BeneFIX Trial Prescription Program Administrator, MedVantx, PO Box 5736, Sioux Falls, SD 57117-5736.

PARTS 1-4: PATIENT INFORMATION

1 Name _____ 2 Date of birth _____

3 Address _____
(Street) (Suite/Floor) (City) (State) (ZIP Code)

(Please note that product cannot be shipped to PO boxes)

I, _____, certify that the patient is not currently receiving BeneFIX therapy.

If guardian, please state relationship to patient _____

(Signature of patient/parent/guardian) _____ Date _____

4 Telephone number ( ) ( )
Day Evening

PARTS 5-10: PHYSICIAN INFORMATION

5 Name _____

6 Professional designation license # (required by law) _____

7 Name of hemophilia treatment center (HTC)* _____

8 Address _____
(Street) (Suite/Floor) (City) (State) (ZIP Code)

9 Business telephone ( ) HTC telephone ( )

10 Fax ( ) Email address _____

*If not a treatment center, please fill in physician name and medical center affiliation.

PARTS 11-13: BeneFIX TRIAL PRESCRIPTION INFORMATION

11 Please note on the prescription whether patient has any allergies and/or is taking concomitant medications. Maximum quantity based on patient weight, 1-month supply up to 20,000 IU.

12 Preferred vial sizes based on patient dosage (subject to availability)

_____ 250-IU vials # _____ 500-IU vials # _____ 1000-IU vials # _____ 2000-IU vials # _____ 3000-IU vials

13 Signature of requesting licensed physician

I agree that I will not resell or bill any third party, including Medicaid or Medicare programs, for any of the complimentary product provided under this trial prescription program. I acknowledge that any patient selected for this program is not currently receiving BeneFIX therapy and has not been previously enrolled in the BeneFIX Trial Prescription Program.

_____
(Signature of physician) (Date of request)

BeneFIX®
Coagulation Factor IX (Recombinant)
Room Temperature Storage

For questions about the BeneFIX Trial Prescription Program, please call 1.844.989.HEMO (4366), Monday through Friday, 9:00 AM to 5:00 PM Eastern Time.

Please see Indication and Important Safety Information on next page and click here for full Prescribing Information.

Indication

BeneFix®, Coagulation Factor IX (Recombinant), is a human blood coagulation factor indicated in adult and pediatric patients with hemophilia B (congenital factor IX deficiency or Christmas disease) for the control and prevention of bleeding episodes and peri-operative management.

Limitations of use:
BeneFix is **NOT** indicated for:

- treatment of other factor deficiencies (eg, factors II, VII, VIII and X),
- treatment of hemophilia A patients with inhibitors to factor VIII,
- reversal of coumarin-induced anticoagulation,
- treatment of bleeding due to low levels of liver-dependent coagulation factors.

Important Safety Information

- BeneFix is contraindicated in patients who have manifested life-threatening, immediate hypersensitivity reactions, including anaphylaxis, to the product or its components, including hamster protein.
- Hypersensitivity reactions, including anaphylaxis, have been reported with BeneFix. Closely monitor patients for signs and symptoms of acute anaphylaxis, particularly during the early phases of initial exposure to the product. Immediately discontinue the administration of the product and initiate appropriate treatment if symptoms occur.
- Patients may develop hypersensitivity to hamster (CHO) protein as BeneFix contains trace amounts.
- BeneFix has been associated with the development of thromboembolic complications, including patients receiving continuous infusion through a central venous catheter. The safety and efficacy of BeneFix administration by continuous infusion have not been established.
- Neutralizing antibodies (inhibitors) have been reported following the administration of BeneFix. If expected plasma factor IX activity levels are not attained, or if the patient presents with an allergic reaction, or if bleeding is not controlled following an expected dose of BeneFix, perform an assay that measures factor IX inhibitor concentration.
- The most common adverse reactions (>5%) from clinical trials were nausea, injection site reaction, injection site pain, headache, dizziness and rash.

Please click here for full Prescribing Information.

BeneFix®
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Patient Authorization Form

This Patient Authorization Form authorizes your health care provider to disclose your health and personal information to MedVantx, the administrator of the BeneFix® Trial Prescription Program, and its employees, representatives, and agents (collectively, "MedVantx") in connection with the BeneFix Trial Prescription Program in accordance with the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("HIPAA").

Authorization

I, _____ hereby authorize _____
First Middle Last Name Name of Physician "health care provider"

to disclose my individually identifiable health and medical information described below to MedVantx solely for the authorized purposes described in this authorization form.

Description of Health and Medical Information That May Be Disclosed

My health care provider may disclose individually identifiable health and other information that supports my participation in the BeneFix Trial Prescription Program. Information disclosed may include my name, address, date of birth, diagnosis/disease treatment, financial information, medical records, and the specialty of my health care provider.

Authorized Purposes

The authorized purposes are: (1) to evaluate my eligibility for inclusion in the BeneFix Trial Prescription Program and (2) if my participation in the program is approved, for the administration of the program to me.

Expiration of Authorization

My authorization shall expire (1) when my participation in the BeneFix Trial Prescription Program is not approved or (2) at the conclusion of my participation in the BeneFix Trial Prescription Program, whichever is earlier.

Acknowledgements

1. I understand that once my health care provider gives MedVantx information about me based on this authorization, my medical and health information may be subject to redisclosure and no longer protected by federal privacy regulations. I further understand and agree that MedVantx may retain my medical and health information as disclosed under this authorization after this authorization expires for purposes related to the administration of the BeneFix Trial Prescription Program. I also understand that in the event of an audit, and only for purposes of such an audit, some information may also be disclosed to Pfizer (the manufacturer of BeneFix), even after this authorization has expired, so long as the audit is for a period of time when this authorization was in effect.

2. I understand that I may refuse to sign this authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my health care provider or to seek payment or my eligibility for benefits. However, I understand that I may not be included in the BeneFix Trial Prescription Program if I refuse to sign this authorization form.

3. I understand that I may revoke my authorization at any time by providing a written notice of same to my health care provider that refers to (or with a copy of) this authorization form. However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my health care provider to MedVantx in reliance of this authorization.

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4 I understand and agree to the following:

Pfizer understands your personal and health information is private. The information you provide will only be used by Pfizer and parties acting on its behalf to send you the materials you requested and other helpful information and updates on BeneFix® or disease information, as well as related treatments, products, offers, and services.

☐ By checking this box, I *also* agree that Pfizer or companies acting on its behalf may send me materials about other health conditions, use my information to develop or improve products and services, or contact me in the future about health-related topics.

Signature of Patient or Patient's Personal Representative

Date

Patient's Name

Name of Personal Representative (if applicable)

Relationship to Patient

HEALTH CARE PROVIDER MUST GIVE PATIENT AND/OR PATIENT'S REPRESENTATIVE A SIGNED COPY OF THIS FORM.
Health care provider has verified Patient Representative's authority to act on Patient's behalf _____ (check).

BeneFix®
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