Copay Rebate Form

PFIZER DERMATOLOGY
patient access™

REBATE PROGRAM INSTRUCTIONS:

If your pharmacy does not accept or cannot process your CIBINQO® (abrocitinib)/ LITFULO® (ritlecitinib)/EUCRISA® (crisaborole) Copay Savings Card, use this rebate form to request reimbursement of your out-of-pocket copay costs for CIBINQO/ LITFULO/EUCRISA.*

1. **Complete** the rebate form below.
2. **Circle** the medication name, the date, and the amount you paid for CIBINQO/ LITFULO/EUCRISA on your original pharmacy receipt. (Cash register receipt is *not* valid.)
3. **Ensure** your pharmacy receipt includes the following information:
   - Patient name and address
   - Pharmacy name, address, and phone number
   - Doctor or healthcare provider name, address, and phone number
   - Prescription # (Rx #), fill date, drug name, strength, NDC #, and quantity
   - Overall prescription price and copay/out-of-pocket expense paid
4. **Send in** the completed rebate form along with your pharmacy receipt:

By mail: Attn: Claims Processing Department, IQVIA, Inc., 430 Mountain Avenue, Suite 105, New Providence, NJ 07974

By fax: 1-631-822-2893 (toll-free)

COMPLETE AND RETURN THIS FORM:

NAME

ADDRESS

CITY

STATE ZIP CODE PHONE

EMAIL

DATE OF BIRTH

COPAY SAVINGS CARD MEMBER ID # DAYS SUPPLY

SIGNATURE DATE

By my signature, I certify that I meet and agree to the terms and conditions listed on this rebate form, as well as the eligibility requirements and restrictions that I received when I activated my card.

To validate, you must sign and date this rebate form. The rebate check will arrive in 6-8 weeks. An additional rebate form is provided in the event it is necessary to submit another request for reimbursement.



Don't forget to sign and date the form. Your signature is required for processing.

QUESTIONS?

Please call 1-833-956-3376
Monday–Friday, 8:00 AM–8:00 PM ET

*Limits, terms, and conditions apply, listed on this page.

Pfizer © 2025 Pfizer Inc. All rights reserved. September 2025 PP-CIB-USA-1933

COPAY SAVINGS CARD: TERMS AND CONDITIONS

By using the Pfizer Dermatology Patient Access™ Copay Savings Card, you acknowledge that you currently meet the eligibility criteria and will comply with the terms and conditions described below:

- You are not eligible to use this card if you are enrolled in a state or federally funded prescription insurance program, including but not limited to Medicare, Medicaid, TRICARE, Veterans Affairs health care, a state prescription drug assistance program, or the Government Health Insurance Plan available in Puerto Rico (formerly known as "La Reforma de Salud").
- Patient must have private insurance. Offer is not valid for cash-paying patients.
- By using this copay card at participating pharmacies, eligible patients with commercial prescription drug insurance coverage for CIBINQO® (abrocitinib) may pay as little as $0 per month. Eligible patients with commercial prescription drug coverage may receive a maximum benefit of [$4,000-$15,000] per calendar year, which is defined by the date of enrollment through December 31st of the enrollment year. After a maximum of [$4,000-$15,000], you will be responsible for paying the remaining monthly out-of-pocket costs. Eligible patients with commercial prescription drug insurance coverage and an FDA approved indication that does not cover CIBINQO may pay $25 per prescription fill. Card may be used for up to a maximum of 13 prescription fills per calendar year.
- By using this copay card at participating pharmacies, eligible patients with commercial prescription drug insurance coverage for LITFULO® (ritlecitinib) may pay as little as $0 per month. Eligible patients with commercial prescription drug coverage may receive a maximum benefit of [$4,000-$15,000] per calendar year, which is defined by the date of enrollment through December 31st of the enrollment year. After a maximum of [$4,000-$15,000], you will be responsible for paying the remaining monthly out-of-pocket costs. Eligible patients with commercial prescription drug insurance coverage and an FDA approved indication that does not cover LITFULO may pay $25 per prescription fill. Card may be used for up to a maximum of 13 prescription fills per calendar year.
- By using this copay card at participating pharmacies, eligible patients with commercial prescription drug insurance coverage for EUCRISA® (crisaborole) may pay as little as $10 per tube. Eligible patients with commercial prescription drug insurance coverage that does not cover EUCRISA may pay as little as $100 per tube. Individual savings are limited to $970 per tube. Individual patient savings are limited to $3,880 in maximum total savings per calendar year.
- This copay card is not valid when the entire cost of your prescription drug is eligible to be reimbursed by your private insurance plan or other private health or pharmacy benefit program.
- You must deduct the value of this copay card from any reimbursement request submitted to your private insurance plan, either directly by you or on your behalf.
- You are responsible for reporting use of the copay card to any private insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the copay card, as may be required. You should not use the copay card if your insurer or health plan prohibits use of manufacturer copay cards.
- This copay card is not valid where prohibited by law.
- The benefit under the co-pay card program is offered to, and intended for the sole benefit of, eligible patients and may not be transferred to or utilized for the benefit of third parties, including, without limitation, third party payers, pharmacy benefit managers, or the agents of either.
- Copay card cannot be combined with any other external savings, free trial, or similar offer for the specified prescription (including any program offered by a third party payer or pharmacy benefit manager, or an agent of either, that adjusts patient cost-sharing obligations, through arrangements that may be referred to as "accumulator" or "maximizer" programs).
- Third party payers, pharmacy benefit managers, or the agents of either, are prohibited from assisting patients with enrolling in the co-pay card program.
- **Copay card will be accepted only at participating pharmacies.**
- **If your pharmacy does not participate, you may be able to submit a request for a rebate in connection with this offer.**
- **This copay card is not health insurance.**
- Offer good only in the United States and Puerto Rico.
- Copay card is limited to 1 per person during this offering period and is not transferable.
- A copay card may not be redeemed more than once per 30 days per patient.
- No other purchase is necessary.
- Data related to your redemption of the copay card may be collected, analyzed, and shared with Pfizer, for market research and other purposes related to assessing Pfizer's programs. Data shared with Pfizer will be aggregated and de-identified; it will be combined with data related to other copay card redemptions and will not identify you.
- Pfizer reserves the right to rescind, revoke, or amend this offer at any time without notice.
- Offer expires [12/31/2027].

For questions or additional support, call 1-833-956-3376, write to Pfizer Inc. at PO Box 29387, Mission, KS 66201, or visit the CIBINQO website at www.Cibinqo.com, the LITFULO website at www.Litfulo.com, or the EUCRISA website at www.Eucrisa.com.