



SUTENT® (sunitinib malate) capsules ENROLLMENT FORM

Phone 1-877-744-5675 or fax 1-800-708-3430 | PO Box 220582, Charlotte, North Carolina 28222-0582

Please complete each section to the fullest extent possible and fax or mail the completed enrollment form to the fax number or address listed above. For possible patient assistance program eligibility, complete all sections of the enrollment form, including patient financial information.

PATIENT INFORMATION (Please print)
(To be completed by the patient or health care provider)

Name: _____
 SSN: _____
 DOB: _____
 Address: _____
 City: _____ State: _____ ZIP code: _____
 Phone number (day): _____
 Phone number (evening): _____
 Gender: M F US resident: Yes No

PATIENT FINANCIAL INFORMATION
(For patient assistance program applicants only)

Number of dependents in household (including applicant): _____
 Please list the current annual household income for each item listed below. Each item must be completed.

| | |
|--|----------|
| Current annual salary | \$ _____ |
| Social Security | \$ _____ |
| Other income | \$ _____ |
| IRA distributions | \$ _____ |
| Interest/dividends | \$ _____ |
| Unemployment compensation | \$ _____ |
| Alimony/child support | \$ _____ |
| Disability | \$ _____ |
| Workers' compensation | \$ _____ |
| Total annual income for entire household | \$ _____ |

Attached is:

- Most recent federal tax return
- W-2 form(s)
- Copy of most recent pay stub
- Statement of Social Security benefits
- Other proof of income

We must receive proof of income **within 30 days** to determine eligibility for assistance. Please submit documentation to support the financial information reported above.

INSURANCE INFORMATION

Do you have health insurance? Yes No
(If yes, complete the information below. Include all health insurance policies.)

Primary insurance company name: _____
 Phone number: _____
 Policy holder name: _____
 Policy holder DOB: _____
 Policy #: _____ Group name/#: _____
 Primary prescription card name: _____
 Phone number: _____
 Policy #: _____ Group name/#: _____
 Secondary insurance company name: _____
 Phone number: _____
 Policy holder name: _____
 Policy holder DOB: _____
 Policy #: _____ Group name/#: _____
 Secondary prescription card name: _____
 Phone number: _____
 Policy #: _____ Group name/#: _____
 Has your insurance company denied coverage for SUTENT? Yes No

Patient Support Program

The SUTENT Patient Call Center program is a free patient support program to help supplement the information that you receive from your health care professional about SUTENT and some side effects patients may experience when taking SUTENT.

If you would like to participate in this informational resource program as well, please check here:

PATIENT CERTIFICATION

I verify and attest that the information I provided is current, complete, and accurate to the best of my knowledge. I understand that I may be contacted to provide additional information. I understand that my information will be used to provide services to me, including but not limited to verification of my insurance coverage and to determine, if applicable, my eligibility for the patient assistance program, and by Pfizer and its agents to administer the First Resource program, including understanding of the services provided, their outcomes, and, in aggregate, information regarding those receiving this assistance. If I apply to the First Resource program, I understand that documentation to verify my financial or insurance information may be requested. I understand that any assistance provided by the First Resource program is temporary and that I may be asked to reapply at designated intervals. I also agree to inform the First Resource program immediately if my income or insurance status changes. I authorize Pfizer and its agents to obtain information from my health care provider(s) or insurance company(ies), to verify the accuracy of any information, to administer the First Resource program, and to, if applicable, refer me to, or to determine my eligibility for, other programs or alternate sources of funding or coverage. I understand that Pfizer and its agents have the right to revise, change, or terminate this program (and the assistance provided) at any time, without notice.

Patient's signature: _____ **Date:** _____

PHYSICIAN STATEMENT OF MEDICAL NECESSITY (To be completed by the health care provider)

Prescriber name and title: _____ NPI: _____
 Prescriber state license number: _____ Prescriber DEA number: _____
 Facility name: _____ Tax ID number: _____
 Address: _____
 City: _____ State: _____ ZIP code: _____
 Office contact name: _____
 Phone number: _____ Fax number: _____
 E-mail address: _____
 Patient diagnosis: Gastrointestinal stromal tumor Renal cell carcinoma Other
 Please provide specific ICD-9 code: _____ Dosing regimen: _____

PHYSICIAN CERTIFICATION

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I certify that SUTENT is medically necessary for this patient and I will be supervising the patient's treatments. I will notify First Resource immediately if SUTENT is no longer medically necessary for this patient's treatment. I certify that I have obtained from my patient all required written authorization for the release to Pfizer and its agents of my patient's personal identification and insurance information. I understand that any information provided is for the use of Pfizer and its agents to provide services including but not limited to verifying my patient's insurance coverage, and to assess, if applicable, my patient's eligibility for participation in the patient assistance program and to otherwise administer the First Resource program, including understanding of the services provided, their outcomes, and, in aggregate, information regarding those receiving this assistance. I understand that application to the patient assistance program does not guarantee that assistance will be obtained. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the patient assistance program, and I agree to immediately notify First Resource if I become aware of changes in the patient's insurance status. I agree that First Resource may contact me for additional information relating to this application either by phone, fax, or any other form of communication. I understand that I am under no obligation to prescribe SUTENT and that I have not received nor will I receive any benefit from Pfizer or its agents for prescribing SUTENT.

Prescriber's signature: _____ Date: _____

SUTENT[®] (sunitinib malate) capsules prescription form

PATIENT INFORMATION

First name: _____ Last name: _____ Unique patient ID: _____
 DOB: _____ Phone number: _____
 Shipping address: _____
 City: _____ State: _____ ZIP code: _____
 Is patient's shipping address correct? Yes No If no, please provide another address below:

Address: _____
 City: _____ State: _____ ZIP code: _____

PRESCRIPTION

Original Rx: _____ Refill: _____ Drug: SUTENT _____ mg
 Directions: 4 weeks on/2 weeks off Continuous dosing Other
 Take _____ capsule(s) Other instructions: _____
 Dispense: 28-day supply Refill _____ times
 Drug allergies: Yes NKDA If yes, please specify drug allergies: _____
 Prescribing physician: _____
 State license number: _____ Expiration date: _____ DEA number: _____
 Address: _____
 City: _____ State: _____ ZIP code: _____
 Phone number: _____ Fax number: _____

Physician's signature: _____ Date: _____

Prescription valid for 1 year.

Please see full prescribing information for indications and complete product information.
 Please fax the completed enrollment form to First Resource at 1-800-708-3430.