Claims Department
P.O. Box 845
Stevens Point, WI 54481
Toll Free 1-866-330-7902

AIG Claims, Inc. is a wholly owned subsidiary of AIG and provides claims administration for the Group Policy provided with your Pfizer Pledge™ Warranty Program.

PFIZER PLEDGE™
PHYSICIAN ATTESTATION FORM
(TO BE COMPLETED BY XALKORI® (crizotinib) PRESCRIBING PHYSICIAN)

Please FAX the **completed** form to 1-715-342-2490 or mail to: Pfizer Pledge Warranty Program, PO Box 845, Stevens Point, WI 54481. For questions, please call 1-866-330-7902, Monday–Friday, 8 am–8 pm ET. For details about how Pfizer collects and uses personal information, including applicable U.S. state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

Patient Information

Patient Name (First/MI/Last): _____

Date of Birth (mm/dd/yyyy): _____

XALKORI Prescribing Physician/Site of Care Information

Are you the physician who prescribed XALKORI for this patient? (check one) ____ YES _____ NO

Prescribing Physician Name (First/MI/Last): _____

Practice/Institution Name: _____

Address, City, State Zip: _____

NPI #: _____

State License #: _____

FAX # (with area code): _____

Contact Name: _____

Contact E-mail: _____

Contact Phone: _____

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Healthcare Provider Pfizer Pledge Attestation for XALKORI

I confirm that my patient was prescribed XALKORI for: (check which applies)

- ☐ Metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK) or ROS1-positive as detected by an FDA-approved test.
- ☐ Pediatric patients 1 year of age and older and young adults with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive.
- ☐ None of the above.

Please provide a brief description for the clinical rationale for discontinuation (NOTE: scans, test results, etc. are not required):

_____

_____

_____

Healthcare Provider Consent

I understand that completing this attestation form does not guarantee that a warranty remedy will be provided to my patient. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. I understand that the information provided on this attestation form is subject to random audits and verification. I understand that my information may be provided to Pfizer for its administration and compliance of the Pfizer Pledge Warranty Program. Pfizer may change or cancel this program at any time. Should Pfizer change or cancel the program, it will continue to honor valid warranty claims related to qualifying doses of Xalkori dispensed during the period in which the program remained in effect.

Healthcare Provider HIPAA and Telephone Consumer Protection Act (TCPA) Attestation
By my signature, I certify that the information I have provided above is true. I also certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pfizer and its employees or agents for purposes relating to the Pfizer Pledge Warranty Program, including, assisting the patient with seeking a warranty claim for a Pfizer medicine through the Pfizer Pledge Warranty Program. I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, Pfizer Pledge Warranty Program, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above. I also give my permission to receive calls related to these services from Pfizer, Pfizer Pledge Warranty Program, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided. I consent to providing my information to Pfizer as it relates to the Pfizer Pledge Warranty Program.

HCP Signature: _____

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Date of Signature: _____

HCP Email Address: _____

August 2021
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