# PP-CIB-USA-2039

# Specialty Pharmacy Copay Savings Program for Non-Covered Patients Ts & Cs
# January 15th, 2026

## TERMS AND CONDITIONS

**By using the Pfizer Dermatology Patient Access™ Specialty Pharmacy Copay Savings Program for Non-Covered Patients (the "Program"), 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 Program 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").
- You must have private insurance that does not cover CIBINQO® (abrocitinib) or LITFULO® (ritlecitinib).
- Offer is only available to patients who have been diagnosed with an FDA-approved indication for CIBINQO® (abrocitinib) or LITFULO® (ritlecitinib).
- No claim for reimbursement for product dispensed pursuant to this offer may be submitted to any third-party payer.
- Assistance may be available for eligible patients for up to a maximum of 13 prescription fills per calendar year or two years in total, which is the lifetime maximum per patient. Eligible patients may pay $25 per prescription fill.
- Refills are subject to limitations. Program offer does not require, nor will be made contingent on, purchase requirements of any kind. Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification.
- This Program is only available at participating pharmacies.
- Offer good only in the U.S. and Puerto Rico. The program is not available to Massachusetts residents.
- Program is not available where prohibited by law.
- Prescription must be provided by a healthcare provider licensed in the U.S. or Puerto Rico.
- Continued eligibility for the Program requires, 1. submission of first appeal within 60 days of enrollment (or within the required payer timeline, if sooner) in the Program and submission of the second appeal, if allowed by the payer, within 60 days of the date of the first appeal denial (or within the required payer timeline, if sooner), 2. satisfying all payer appeal requirements and 3. patients schedule their initial prescription dispense within 60 days of enrollment. ***Pfizer may conduct periodic benefits investigation to determine if there is a payer coverage change. If payer coverage is identified, and allowed by the payer, Pfizer may require*** submission of a new Prior Authorization request and an appeal, if denied, within 60 days (or within the required payer timeline, if sooner) of either, 1. the date of completion of the benefits investigation, provided by the Program to the patient's authorized healthcare provider, or 2. the date a new submission is allowed by the payer, for continued eligibility in the program, whichever is later.
- At 12 months of Program enrollment, an updated prescription and benefits investigation is required to confirm continued eligibility. All payer appeal timelines must be met for continued assistance. The Program is applicable to all CIBINQO® (abrocitinib) or LITFULO® (ritlecitinib) formulations.

- Additional eligibility criteria may apply.
- This Program may not be redeemed more than once per 30 days per patient.
- No other purchase is necessary.
- Offer expires 12/31/XXXX.
- For questions or additional support, call 1-800-471-0197, or write to Pfizer Inc., 430 Mountain Avenue, Suite 105, New Providence, NJ 07974