DUPIXENT myway™ Enrollment Form

Fax 1-844-387-9370 | Phone 1-844-DUPIXENT [1-844-387-4936] Option 1

To prevent delays, complete all fields and ***FAX ALL 4 PAGES*** *to number above.* For additional assistance, call us at number above M–F, 8 AM–9 PM ET

1 Patient Information

Name

DOB / /

Sex ☐ M ☐ F

Address

City State Zip

E-mail

Preferred Language (if not English)

Preferred Phone

Alternate Phone

Best Hours to Call

Voice Mail Message ☐ Preferred Phone ☐ Alternate Phone ☐ No Message

Text Message ☐ Preferred Phone ☐ Alternate Phone ☐ No Message

☐ By checking this box, I indicate that I have read the Text Messaging Consent in Section 7 and expressly consent to receive text messages by or on behalf of the Program.

Patient Authorization

I have read and agree to the Patient Certifications included in Section 7

/ /

Patient Signature/Legal Representative MM DD YYYY

Relationship to Patient (If signed by someone other than the patient, *please describe your authority to sign on behalf of the patient.*)

I have read and agree to the Patient Authorization to Use and Disclose Health Information in Section 8

/ /

Patient Signature/Legal Representative MM DD YYYY

2 Insurance

Please attach copies of front and back of primary and prescription cards.

Please fill out Section 6 if you do not have health insurance.

Primary Insurance ☐ No insurance

Insurance Phone

Policy ID # Group #

Policy Holder Name (First/Last)

Relationship to Patient

Rx Insurance (if different)

Rx Insurance Phone

Policy ID # Group #

Rx Bin # Rx PCN #

3 Prescriber

Prescriber Name

Site/Facility Name

Prescriber NPI # Group Tax ID #

Address

City State Zip

Specialty State License #

Office Contact

E-mail

Phone Fax

My preferred specialty pharmacy is:

Preferred Specialty Pharmacy Name HEALTHVIA PHARMACY

Phone 888 - 601 - 8711 Fax 844 - 436 - 9128

☑ I have already sent this prescription to the specialty pharmacy above. By checking this box, I acknowledge this pharmacy's role in seeking to secure coverage on the patient's behalf.

4 Prescription

R_x DUPIXENT (dupilumab) 300 mg/2 mL Prefilled syringe 2-Pack

INITIAL DOSE: **600** mg

\# of 2-packs:

☐ SIG: **2** injections subcutaneously on Day 1 Qty: 1

MAINTENANCE: **300** mg

☐ SIG: **1** injection every 2 weeks starting on Day 15 Qty: Refills:

MAINTENANCE: Other

Dose: Frequency:

☐ SIG: Qty: Refills:

Known drug allergies

NY state prescribers, please submit prescription on an original NY State prescription blank.

/ /

Prescriber Signature (No stamps) ☐ Dispense as written MM DD YYYY

My signature certifies that the person named on this form is my patient; the information provided on this application, to the best of my knowledge, is complete and accurate; and that therapy with DUPIXENT is medically necessary. I understand that my patient's information provided to Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (the "Alliance") is for the use of *DUPIXENT MyWay*™ solely to verify my patient's insurance coverage; to assess, if applicable, my patient's eligibility for patient assistance and other support programs; and to otherwise administer *DUPIXENT MyWay* for the patient. I request *DUPIXENT MyWay* to conduct a benefits investigation for my patient and authorize *DUPIXENT MyWay* to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy designated by the patient per their benefit plan. If this prescription is not so designated, *DUPIXENT MyWay* is authorized to transmit this prescription to a network pharmacy it selects or to the pharmacy I have indicated. I consent to *DUPIXENT MyWay* contacting me by fax, mail, or e-mail to provide additional information about DUPIXENT injection or *DUPIXENT MyWay*. I agree that *DUPIXENT MyWay* may revise, change, or terminate any program services at any time without notice to me.

Complete entire form and fax ***ALL 4 PAGES*** *to DUPIXENT MyWay at* ***1-844-387-9370***

Please click here for full Prescribing Information.

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Patient Name ______________________________

Prescriber Name ______________________________ NPI# ______________________________

5 Clinical

DIAGNOSIS

ICD-10 code: **L.20.**__ __ **L.20.**__ __ **L.20.**__ __

Years since diagnosis: ________

☐ Patient is 18 or over

☐ Patient has moderate to severe atopic dermatitis (AD)* that is inadequately controlled on prior or current topical therapy

*Moderate to severe AD is defined as moderate to severe erythema and moderate to severe papulation/infiltration.[1]

SEVERITY

Body Surface Area (BSA) involved:

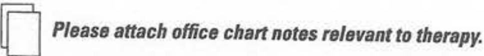
☐ under 10% ☐ 10% or more

Sensitive areas affected (Check all that apply):

☐ hands ☐ feet ☐ face and neck

☐ genitals/groin ☐ scalp ☐ intertriginous areas

☐ other ________________



Please attach office chart notes relevant to therapy.

1. Futamura M, Leshem YA, Thomas KS, Nankervis H, Williams HC, Simpson EL. A systematic review of Investigator Global Assessment (IGA) in atopic dermatitis (AD) trials: many options, no standards. *J Am Acad Dermatol.* 2016;74:288-294.

CURRENT AND PRIOR THERAPIES — DURATION

Topical Therapies:

________________________ ________ to ________

________________________ ________ to ________

☐ Topical therapies are inappropriate for this patient

Rationale:

Systemic Corticosteroids, Immunosuppressants and/or Phototherapy:

________________________ ________ to ________

________________________ ________ to ________

________________________ ________ to ________

☐ Systemic corticosteroids are inappropriate for this patient

☐ Immunosuppressants are inappropriate for this patient

☐ Phototherapy is inappropriate for this patient

Rationale:

6 Household Income *Required if enrolling in the DUPIXENT MyWay Patient Assistance Program*

How many people live in your household? _______

Total annual household income ☐ $0 to $100,000 ☐ Greater than $100,000

(Includes salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.)

To qualify for the *DUPIXENT MyWay™* Patient Assistance program, I understand that I must not have confirmed insurance coverage for DUPIXENT and I must meet certain income and other eligibility requirements. *DUPIXENT MyWay* may ask for proof of income at any time for the purpose of audit/verification. If requested, I agree to provide proof of income within thirty (30) days of the request. Continuation in the program is conditioned upon timely verification of income. In addition, I agree to notify *DUPIXENT MyWay* if my insurance situation changes.

Complete entire form and fax ***ALL 4 PAGES*** *to DUPIXENT MyWay at* ***1-844-387-9370***

Please click here for full Prescribing Information.

US-DAD-14043, US.DUP.17.02.026

Patient Name

Prescriber Name NPI#

7 Patient Certifications

Please read the following carefully, then date and sign where indicated in Section 1 of page 1

I am enrolling in the *DUPIXENT MyWay™* Program (the "Program") and authorize Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together the "Alliance") to provide me services under the program, as described in the Program Enrollment Form and as may be added in the future. Such services include medication and adherence communications and support, medication dispensing support, coverage and financial assistance support, disease and medication education, injection training, and other support services (the "Services").

I agree to my enrollment in the *DUPIXENT MyWay* Copay Card program if confirmed as eligible, understand that Copay Card information will be sent to my designated specialty pharmacy/in-network specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or copayment for DUPIXENT® injection will be made in accordance with the Program terms and conditions.

If I am completing Section 6, I confirm my agreement with the conditions set forth in Section 6, and certify that the number of people in my household and my household income are true and accurate to the best of my knowledge.

I authorize the Alliance to contact me by mail, telephone, or e-mail, or, if I indicate my agreement and consent on page 1, by text*, with information about the Program, atopic dermatitis (AD) and products, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize the Alliance to de-identify my health information and use it in performing research including linkage with other de-identified information the Alliance receives from other sources, education, business analytics, marketing studies or for other commercial purposes. I understand that members of the Alliance may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services or to send the communications listed above (the "Communications"). I understand and agree that the Alliance may use my health information for these purposes and may share my health information with my doctors, specialty pharmacies, and insurers.

I understand that I do not have to enroll in the Program or receive the Communications, and that I can still receive DUPIXENT injection, as prescribed by my physician. I may opt out of receiving Communications, individual support services offered by the Program, including the *DUPIXENT MyWay* Copay Card, or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1-844-387-4936 or by sending a letter to *DUPIXENT MyWay*, 1800 Innovation Point, Fort Mill, SC 29715. I also understand that the Services may be revised, changed, or terminated at any time.

You may keep a copy of this form for your records.

Text Messaging Consent:

*I acknowledge that by checking the Text Messaging Consent box on page 1, I expressly consent to receive text messages from or on behalf of the Program at the mobile telephone number(s) that I provide.

I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify the Alliance promptly if any of my number(s) change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by texting **SMSSTOP** to **39771** from my mobile phone, and that I can get help for text messages by texting **SMSHELP** to **39771**. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. I understand that my consent is not required as a condition of purchasing any goods or services from Regeneron Pharmaceuticals, Inc., Sanofi US, or their affiliates. Message and data rates may apply.

*Complete entire form and fax **ALL 4 PAGES** to DUPIXENT MyWay at **1-844-387-9370***

Please click here for full Prescribing Information.

Patient Name

Prescriber Name NPI#

8 Patient Authorization to Use and Disclose Health Information

Please read the following carefully, then date and sign where indicated in Section 1 of page 1

I authorize my healthcare providers and staff, my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies that dispense my medication to disclose to Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together, the "Alliance") health information about me, including information related to my medical condition and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the Program ("My Information") for the purposes of enrolling me in and providing certain services, including:

- to determine if I am eligible to participate in *DUPIXENT MyWay*™ coverage assistance programs, patient assistance programs, or other support programs (the "Program")
- to investigate my health insurance coverage for DUPIXENT® injection
- to obtain prior authorization for coverage
- to assist with appeals of denied claims for coverage
- for the operation and administration of the Program
- to refer me to, or to determine my eligibility for, other programs, foundations, or alternative sources of funding or coverage that may be available to provide assistance to me with the costs of my medication

I understand and agree that my healthcare providers, health insurers, and specialty pharmacy(ies) may receive remuneration from the Alliance in exchange for disclosing My Information to the Alliance and/or for providing me with support services in connection with the Program.

Once My Information has been disclosed to the Alliance, I understand that federal privacy laws may no longer protect it from further disclosure. However, the Alliance agrees to protect My Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise allowed by law.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits or Alliance medications. However, if I do not sign this Authorization, I understand that I will not be able to participate in the Program.

I understand that this Authorization expires 18 months from the date support is last provided under the Program, subject to applicable law, unless and until I withdraw (take back) this Authorization before then. Further, I understand that I may withdraw this Authorization at any time by mailing or faxing a written request to *DUPIXENT MyWay* at 1800 Innovation Point, Fort Mill, SC 29715; Fax: 1-844-387-9370. Withdrawal of this Authorization will end my participation in the Program and will not affect any disclosure of My Information based on this Authorization made before my request is received and processed by my healthcare providers and staff, my health insurers, and specialty pharmacies.

I understand that I may request a copy of this Authorization.

*Complete entire form and fax **ALL 4 PAGES** to DUPIXENT MyWay at **1-844-387-9370***

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