MyPraluent™ Enrollment Form

Complete and fax pages 1 and 2 to MyPRALUENT™ at 1-844-872-5447. For additional assistance, call us at 1-844-PRALUENT (1-844-772-5836), M-F 8AM-8PM ET.

SECTION 1 - Support Requested (check all that apply)

☐ **Benefits Investigation**

☐ **MyPRALUENT Copay Card** (eligible MyPRALUENT patients will be automatically enrolled)

☐ **MyPRALUENT Patient Assistance Program** (optional program for eligible uninsured patients or those lacking coverage for PRALUENT® (alirocumab); please see Household Income section 6)

☐ **Clinical Nursing Support** (including product administration training)

SECTION 2 - Patient Information

Patient Name _____ DOB _____ Sex ☐ M ☐ F

Street Address _____

City _____ State _____ ZIP _____-_____

Contact/Caregiver _____

Primary Phone _____ Other Phone _____

Best time to contact ☐ Morning ☐ Afternoon ☐ Evening

Voice mail message ☐ Primary Phone ☐ Other Phone ☐ No Message

Email _____

I have read and agree to the Patient Certifications included in section 7 and Patient Authorization To Use And Disclose Health Information in section 8.

Sign _____ _____ _____

Patient Signature/Legal Representative* Date 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.

SECTION 3 - Insurance Information (please attach copies of front and back of medical and prescription cards)

PRIMARY INSURER

Insurer _____ ☐ No Insurance

Insurance Phone _____

Policy ID Number _____

Group Number _____

PRESCRIPTION DRUG INSURER

Insurer _____

Insurance Phone _____

Policy ID Number _____ Group Number _____

Rx BIN Number _____ Rx PCN Number _____

SECTION 4 - Prescriber And Rx Information

For use by network specialty pharmacy only.

Prescriber Name _____

Site/Facility Name _____

Address _____

City _____ State _____ ZIP _____-_____

Phone _____ Fax _____

Office Contact Name _____

Office Contact Email _____

NPI # _____ State License # _____

Prescriber Specialty Area _____

Rx Information: PRALUENT® (alirocumab) injection

☐ 75 mg/mL Pre-Filled **Pen** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

☐ 150 mg/mL Pre-Filled **Pen** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

☐ 75 mg/mL Pre-Filled **Syringe** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

☐ 150 mg/mL Pre-Filled **Syringe** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

Sharps container and alcohol pads to be provided.

Drug Allergies _____ ☐ NKDA

NY State Prescribers: Please submit prescription on an original NY State prescription blank.

Sign _____ _____

Prescriber Signature (no stamps) (Dispense as Written) **Date MM/DD/YYYY**

Sign _____ _____

Prescriber Signature (no stamps) (Substitution Permitted) **Date MM/DD/YYYY**

MyPRALUENT Bridge Program (for eligible patients to temporarily receive PRALUENT, free of charge)

For use by Bridge specialty pharmacy only.

I authorize for my patient one or more months of temporary shipments of PRALUENT during a benefits determination delay or during the appeals process after an initial coverage denial for PRALUENT by the patient's insurer. I authorize MyPRALUENT to forward this prescription to the pharmacy dispensing the MyPRALUENT Bridge Program product to the patient named herein.

_____

Supervising Prescriber Name (if applicable)

Bridge Program Rx Information: PRALUENT® (alirocumab) injection

☐ 75 mg/mL Pre-Filled **Pen** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

☐ 150 mg/mL Pre-Filled **Pen** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

☐ 75 mg/mL Pre-Filled **Syringe** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

☐ 150 mg/mL Pre-Filled **Syringe** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

Sharps container and alcohol pads to be provided.

Sign _____ _____

Prescriber Signature (no stamps) (Dispense as Written) **Date MM/DD/YYYY**

Sign _____ _____

Prescriber Signature (no stamps) (Substitution Permitted) **Date MM/DD/YYYY**

☐ Check this box to initiate a benefits investigation without a patient signature in section 2. By checking this box, I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to reimbursement support programs such as MyPRALUENT and the Alliance for purposes of conducting an investigation of my patient's health insurance coverage benefits for PRALUENT.

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 PRALUENT is medically necessary. I understand that my patients' information provided to Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (the "Alliance"), is for the use of MyPRALUENT 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 MyPRALUENT for the patient. I request MyPRALUENT to conduct a benefit investigation for my patient and authorize MyPRALUENT to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan; provided that if this prescription is not so designated, MyPRALUENT is authorized to transmit this prescription to a network pharmacy it selects, or to the pharmacy otherwise indicated. I consent to MyPRALUENT contacting me by fax, mail, or email to provide additional information about PRALUENT or MyPRALUENT, and that MyPRALUENT may revise, change, or terminate any program services at any time without notice to me.

Prior to transmittal of any personal health information ("PHI"), obtain the legally required Patient Authorizations for verification services.

Please click here for full Prescribing Information.

MyPraluent™ Enrollment Form

Fax completed pages 1 and 2 to 1-844-872-5447.

Patient Name _____

SECTION 5 - Treatment Information

☐ New Start
☐ Reauthorization
☐ Continuation (new insurance)

ICD-10 Diagnosis Codes

Hypercholesterolemia (MUST select at least one)

☐ E78.0 (Pure Hypercholesterolemia, including HeFH)
☐ E78.2 (Mixed Hyperlipidemia)
☐ E78.4 (Other Hyperlipidemia)
☐ E78.5 (Unspecified Hyperlipidemia)

ASCVD-Specific Code(s): _____

For Clinical ASCVD patients, MUST select the appropriate code(s) for Hypercholesterolemia and include the specific ASCVD diagnosis code.

Click here to access an ICD-10 coding reference list.

LDL-C on treatment _____ mg/dL **Date:** mm/yy_____

Previous And/Or Current Lipid-Lowering Treatments (dose mg/day)

☐ None ☐ Yes (please indicate below)

☐ atorvastatin	☐ 10	☐ 20	☐ 40	☐ 80	
☐ ezetimibe	☐ 10				
☐ pravastatin	☐ 10	☐ 20	☐ 40	☐ 80	
☐ rosuvastatin	☐ 5	☐ 10	☐ 20	☐ 40	
☐ simvastatin	☐ 5	☐ 10	☐ 20	☐ 40	☐ 80

☐ Other _____

Failure on or contraindications to any of the above therapies?

_____

_____

_____

SECTION 6 - Household Income

(required if requesting MyPRALUENT™ Patient Assistance for patients without insurance coverage for PRALUENT® (alirocumab) injection)

Total Number of People within Household (including applicant) _____

Total Annual Household Income $ _____ (current annual household income includes annual gross salary/wages, Social Security income, unemployment insurance benefits, disability income, workers compensation, and any other income for the Household.)

To qualify for the MyPRALUENT Patient Assistance Program, I understand that I must not have confirmed insurance coverage for PRALUENT, and I must meet certain income and other eligibility requirements. MyPRALUENT 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 MyPRALUENT if my insurance situation changes.

Fax pages 1 and 2 to 1-844-872-5447.

Please click here for full Prescribing Information.

SECTION 7 - Patient Certifications (Please read the following carefully, then date and sign where indicated in section 2 of page 1)

I am enrolling in the MyPRALUENT™ Program (the "Program") and authorize Regeneron Pharmaceuticals, Inc., Sanofi US, and their 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 MyPRALUENT 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 co-payment for PRALUENT® (alirocumab) 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 email, with information about the Program, hypercholesterolemia 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, 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 PRALUENT, as prescribed by my physician. I may opt out of receiving Communications, individual support services offered by the Program, including the MyPRALUENT Copay Card, or opt out of the Program entirely at any time by notifying a Program representative by telephone at **1-844-PRALUENT** or by sending a letter to MyPRALUENT, 1670 Century Center Parkway, Memphis, TN 38134.

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

SECTION 8 - Patient Authorization To Use And Disclose Health Information (Please read the following carefully, then date and sign where indicated in section 2 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 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 MyPRALUENT™ coverage assistance programs, patient assistance programs or other support programs
- to investigate my health insurance coverage for PRALUENT® (alirocumab) 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 MyPRALUENT coverage assistance programs.

I understand that this Authorization shall remain in effect until my participation in the MyPRALUENT Program ends 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 MyPRALUENT at 1670 Century Center Parkway, Memphis, TN 38134; Fax: 1-844-872-5447. Withdrawal of this Authorization will end my Participation in the MyPRALUENT coverage assistance programs 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.

Please click here for full Prescribing Information.

SANOFI REGENERON

Praluent® (alirocumab) Injection 75mg/mL 150mg/mL