PASS
PATIENT ASSISTANCE SUPPORT

Patient Assistance Program Enrollment Form

Do I qualify for PASS?

Need help paying for your medicine? In many cases, we can help. PASS has a financial solution for eligible patients, regardless of your insurance status. You may qualify for assistance with the cost of your medication if you meet these eligibility requirements.

You are taking the following medication(s) for a US Food and Drug Administration–approved indication available through PASS

✓ PRALUENT® (alirocumab) injection 75 mg/mL, 150 mg/mL

Your insurance

✓ I am uninsured or insured with no pharmacy coverage

or

✓ I am a Medicare patient with prescription coverage and I meet the income restrictions described below

Your residency

✓ I am a resident of the 50 United States, the District of Columbia, or Puerto Rico

Your income eligibility

I may qualify for the standard Patient Assistance Program (PAP) if[a]:

✓ I have demonstrated my household income is no more than 500% of the federal poverty level (FPL), shown in the chart below[b]

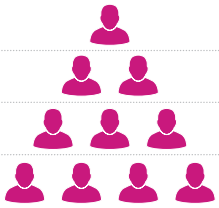
I may qualify for the Medicare Part D PAP if[c]:

✓ I have demonstrated my household income is no more than 500% of the applicable FPL, shown in the chart below[b]

✓ I am ineligible to receive Extra Help for my Medicare Part D drug costs. If your household income is less than 200% of the FPL, you will be required to provide a copy of your Extra Help Notice of Denial

For information about Extra Help, click here

PASS income eligibility requirements

Number of people in your household	Maximum income level to qualify for PASS (500% of the FPL)
	$60,700 for a household of 1
	$82,300 for a household of 2
	$103,900 for a household of 3
	$125,500 for a household of 4

For households exceeding 4 members, add $21,600 for each additional member to the $125,500 referenced above.

[a]Eligibility continues for up to 12 months. Patients whose insurance status or other eligibility status changes will be discharged from the program earlier. Patients must reapply every 12 months.
[b]All patients are subject to a soft credit check prior to approval.
[c]Eligibility continues until the end of the calendar year. Patients must reapply annually.

Steps for enrolling in the PASS Program

Step 1

Complete the Patient Information, Household Income, and Health Insurance Status sections (Sections 1, 3, and 4). Ensure your prescribing physician fills out the Facility and Prescribing Information section (Section 2). **Make sure all sections are complete!**

Step 2

If you have insurance, fill out the Insurance Information section (Section 5). Make sure you report all insurance you have, including Medicare, Medicaid, or other government programs

Step 3

Sign the Authorization to Use and Disclose Health Information and Patient Certification section (Section 6)

Step 4

Fax all completed, signed forms to 1-844-855-7278 or mail to PO Box 592188, Orlando, FL 32859-2188

For additional assistance, call us at 1-844-855-PASS (1-844-855-7277)

Fax all completed, signed forms to 1-844-855-7278 or mail to PO Box 592188, Orlando, FL 32859-2188

Please click here for full Prescribing Information or visit www.PRALUENT.com.

For AssistRx use only: Patient ID _____ Trans ID _____

SECTION 1 Patient Information

Patient First Name _____ **Patient Last Name** _____ **Middle Initial (if applicable)** _____ **Gender** ☐ M ☐ F

Street Address _____

City _____ **State** _____ **ZIP Code** _____

Date of Birth _____ **Last 4 Digits of Social Security Number** _____

(If you do not have a Social Security number, you may skip this question)

Home Phone _____ ☐ **Primary Phone** **Mobile Phone** _____ ☐ **Primary Phone**

OK to Leave Voicemail Message? ☐ Home Phone ☐ Mobile Phone **Best Time of Day to Call** _____ ☐ AM ☐ PM

E-mail _____

Alternate Contact/Caregiver Name _____ **Alternate Contact/Caregiver Phone** _____

Patient's Primary Language ☐ English ☐ Spanish ☐ Other _____

I am a resident of the 50 United States, the District of Columbia, or Puerto Rico ☐ Yes ☐ No

SECTION 2 Facility and Prescribing Information (To be completed by your prescribing doctor)

Prescribing Physician Name _____

Site/Facility Name _____

Office Contact Name _____ **Office Contact E-mail** _____ **Office Contact Phone** _____

Street Address _____

City _____ **State** _____ **ZIP Code** _____

NPI Number _____ **Group Tax ID Number** _____

State License Number _____

Phone _____ **Fax** _____ **Prescriber Specialty Area** _____

☐ **Check here to receive confirmation of enrollment in PASS.**

Rx Information: PRALUENT® (alirocumab) injection

☐ 75 mg/mL Pre-Filled Pen 2-Pack SIG: 75 mg (1 mL) subcutaneously every 2 weeks Qty: 90 day Refills_____

☐ 150 mg/mL Pre-Filled Pen 2-Pack SIG: 150 mg (1 mL) subcutaneously every 2 weeks Qty: 90 day Refills_____

☐ 150 mg/mL Pre-Filled Pen 2-Pack SIG: 300 mg (2×150 mg/mL) subcutaneously every 4 weeks (monthly) Qty: 90 day Refills_____

Sharps container available upon request.

Drug Allergies _____ ☐ NKDA

NY state prescribers: Please submit prescription on an original NY state prescription blank.

Prescriber Certification

My signature below 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 therapy with the product prescribed is medically necessary. I understand that my patient's information provided to Regeneron Pharmaceuticals, Inc., Sanofi US, and their agents is for the use of PASS solely to verify my patient's insurance coverage; to assess, if applicable, my patient's eligibility for patient assistance; and to otherwise administer the product prescribed for the patient. I request that PASS conduct a benefit investigation for my patient and I authorize PASS to act on my behalf for the limited purposes of transmitting this prescription to the PAP dispensing pharmacy. I understand that free product is not contingent on any purchase obligations. I further acknowledge that no medication received free of charge under the Program shall be offered for sale, trade, or barter, and that no claim for reimbursement of either PRALUENT or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer in connection with PRALUENT provided for free under the Program. I understand and acknowledge that PASS may revise, change, or terminate any program services at any time without notice to me.

ICD-10-CM Diagnosis Codes

Select at least one primary and one secondary ICD-10-CM code.

Primary diagnosis (MUST select at least one)

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

If E78.2, E78.4, or E78.5 is selected, select a secondary diagnosis code as applicable

Include as many appropriate clinical atherosclerotic cardiovascular disease (ASCVD) codes as necessary to support your patient's diagnosis.

- Transient cerebral ischemic attack ☐ G45. _
- Ischemic heart diseases ☐ I21. _ _ ☐ I22. _ ☐ I23. _
- Chronic ischemic heart disease ☐ I25. _ _
- Cerebrovascular diseases ☐ I63. _ _ ☐ I65. _ _ ☐ I66. _ _ ☐ I67._ _
- Atherosclerosis ☐ I70. _ _
- Other peripheral vascular diseases ☐ I73. _ _
- Other ☐ __. _ _

_____

Supervising Prescriber Name
(If applicable)

SIGN _____

Prescriber Signature **Date** MM/DD/YYYY
(No stamps) (Dispense as written)

SIGN _____

Supervising Prescriber Signature **Date** MM/DD/YYYY
(No stamps) (Substitution permitted)

For additional assistance, call us at 1-844-855-PASS (1-844-855-7277)

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Please click here for full Prescribing Information or visit www.PRALUENT.com.

SECTION 3 Household Income

Your income

What is your total annual household income?_____ **Number of people in your household, including you** _____

Total annual household income includes annual gross salary/wages, Social Security income, unemployment insurance benefits, disability income, worker's compensation, and any other income for your household.

To qualify for the PASS Program, I understand that either (a) I do not have insurance coverage for the product prescribed or (b) I have coverage through my Medicare Part D plan and meet income restrictions. PASS 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. Enrollment and continuation in the program is conditioned upon timely verification of income. In addition, I agree to notify PASS if my insurance situation changes.

Other assets (Do NOT count your home, vehicle, personal possessions, life insurance, burial plots, irrevocable burial contracts, or back payments from Social Security or Supplemental Security Income)

If you are married and living with your spouse: Are your combined savings, investments, and real estate more than $11,340? ☐ Yes ☐ No

If you are not married or not living with your spouse: Are your combined savings, investments, and real estate worth more than $7560? ☐ Yes ☐ No

SECTION 4 Health Insurance Status

Do you have health insurance? ☐ Yes ☐ No ☐ Unsure

Health insurance includes insurance provided through your employer, individual coverage, or Medicare, Medicaid, or other government-issued insurance

Do you have Medicare? ☐ Yes ☐ No ☐ Pending

If yes, what is your Medicare effective date? ____/___/____

Do you have Medicare Part D? ☐ Yes ☐ No ☐ Pending

If you have Medicare Part D and have applied for Medicare's Extra Help program, which of the following decisions did you receive? ☐ Full support ☐ Partial support ☐ Denied

(Please supply the decision letter from Social Security, if you applied)

Do you have Medicaid? ☐ Yes ☐ No ☐ Pending ☐ Denied

If yes, is it emergency Medicaid? ☐ Yes ☐ No ☐ Pending

(Please provide your Medicaid insurance information, even if you only have emergency Medicaid)

Are you pregnant? ☐ Yes ☐ No

Are you legally blind or have you received a Social Security disability status? ☐ Yes ☐ No

Do you receive Social Security disability benefits? ☐ Yes ☐ No

Are you a parent or caretaker of a child aged 18 years or younger? ☐ Yes ☐ No

Are you eligible for any federal, state, or local government programs, including Veteran's Affairs, Department of Defense, or Indian Health Service? ☐ Yes ☐ No ☐ Pending

SECTION 5 Insurance Information

If you answered **yes** to having health insurance, please provide the following information. If you answered **no**, you may skip this section.

Primary Insurer

Insurer Name _____ Insurer Phone _____

Policy ID Number _____ Group Number _____

Secondary Insurer

Insurer Name _____ Insurer Phone _____

Policy ID Number _____ Group Number _____

Prescription Drug Insurer, if separate from your medical insurance

(The card you use at the pharmacy, rather than the one you use at your doctor's office)

Insurer Name _____ Insurer Phone _____

Policy ID Number _____ Group Number _____

Rx BIN Number _____ Rx PCN Number _____

For AssistRx use only: Patient ID _____ Trans ID _____

SECTION 6 Authorization to Use and Disclose Health Information and Patient Certification

The Patient Assistance Support program, PASS® (the "Program"), is an assistance program supported by Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together, the "Alliance") that provides qualifying patients with Alliance products at no cost.

Authorization to Disclose Information:

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 the Alliance relevant health information about me, including information related to my medical condition and treatment, health insurance coverage, claims, and prescription fill/refill information (together, "My Information"), for the purposes of providing the Program services, including:

- To use the information I provided on the PASS application form to determine if I am eligible for the Program and to assist in my continued participation in the Program.
- To investigate my health insurance coverage for Alliance medications that I have been prescribed.
- Use my Social Security number to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. This is a soft inquiry and will not affect your credit score.
- To use my Social Security number and/or additional demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that upon request, the Alliance will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it.
- To communicate with me about my participation in the Program (for example, contact me for missing information or for fulfillment of product).

I understand and agree that:

- My healthcare providers, Health Insurers, and specialty pharmacy(s) may receive remuneration from the Alliance in exchange for disclosing My Information to the Alliance and/or for providing me with support services for Alliance medications.
- 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 required by law.
- I understand that I do not have to sign this Authorization and that I may revoke it at any time, but if I refuse to sign or revoke my authorization, I will not be able to receive assistance from the Program.
- A decision by me to not sign or to revoke this Authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits or Alliance medications outside of the Program.

(continued on next page)

For AssistRx use only: Patient ID _____ Trans ID _____

SECTION 6 Authorization to Use and Disclose Health Information and Patient Certification (cont'd)

I understand that I may withdraw (take back) this Authorization at any time, or request removal of any of My Information that was previously disclosed to the Alliance, by mailing or faxing a written request to The Alliance at 4700 Millenia Blvd, Suite 500 Orlando, FL 32839; Fax: 1-844-855-7278.

This Authorization expires 18 months from the date support is last provided. I understand that I may request a copy of this authorization.

Patient Certification:

I understand that completing the Program application form is not a guarantee of eligibility for the Program.

I also understand that the Alliance may change or discontinue the Program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year.

I understand that if I am currently enrolled in a Medicare Part D plan, I cannot utilize my Part D plan benefits for products received through the Program for the duration of my enrollment in the Program.

I understand that free product is not contingent on any purchase obligations.

Any medication I receive through the Program will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D. The Program will communicate with my Medicare Part D plan to notify them of the assistance I am receiving.

I also certify that:

- The information I provided on the Program application form is complete and accurate.
- I will not request reimbursement from any insurance carrier or government health benefit program for Alliance products that I receive from the Program.
- I will notify the Program within thirty (30) days if my financial status or health insurance coverage changes.
- If I decide to enroll or have been "auto-enrolled" in a Medicare Part D plan, I will inform the Program immediately at the number below.

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)

SANOFI REGENERON