MyPraluent® Enrollment Form

Complete the MyPRALUENT® Enrollment Form and fax all 4 pages and all supporting documentation 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.

For MyPRALUENT use only: Patient ID ____________ Trans ID ____________

PATIENT TO FILL OUT

SECTION 1 - Patient Information

Patient Name ____________ DOB ______ Sex ☐ M ☐ F
Street Address ____________
City ____________ State ____ ZIP ______ - ______
Contact/Caregiver ____________
Preferred Patient Language ____________
Email ____________

Phone ____________
Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening
Voice mail message: ☐ Yes ☐ No Message
☐ By checking this box, I indicate that I have read the Text Messaging Consent in section 8 and expressly consent to receive text messages by or on behalf of the Program.

I have read and agree to the Patient Authorization to Use and Disclose Health Information in section 7.

Sign **Patient Signature/Legal Representative** ____________ Date MM/DD/YYYY ______ **Legal Representative's 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 Certifications in section 8.

Sign **Patient Signature/Legal Representative** ____________ Date MM/DD/YYYY ______ **Legal Representative's Relationship to Patient** (if signed by someone other than the patient, please describe your authority to sign on behalf of the patient) ____________

SECTION 2 - Insurance Information (please attach copies of front and back of medical and prescription cards; if attached, you can leave this area blank)

PRIMARY INSURER

Insurer ____________ ☐ No Insurance
Insurance Phone ____________
Policy ID # ____________
Group # ____________

PRESCRIPTION DRUG INSURER ☐ No Insurance

Insurer ____________ ☐ Recently Lost Insurance Coverage
Insurance Phone ____________
Policy ID # ____________ Group # ____________
Rx BIN # ____________ Rx PCN # ____________

PRESCRIBER TO FILL OUT

SECTION 3 - Prescriber and Rx Information

Prescriber Name ____________
Site/Facility Name ____________
Address ____________
City ____________ State ____ ZIP ______ - ______
Phone ____________ Fax ____________
Office Contact Name ____________
Office Contact Email ____________
Prescriber NPI # ____________ State License # ____________
Prescriber Specialty Area ____________
Are you the patient's primary care provider? ☐ Yes ☐ No
☐ Check this box to receive fax confirmation of enrollment into MyPRALUENT.

Rx Information: PRALUENT® (alirocumab) injection

☐ 75 mg/mL Pre-Filled Pen 2-Pack
SIG: 75 mg (1 mL) subcutaneously every 2 weeks Qty ____ Refills ____
☐ 150 mg/mL Pre-Filled Pen 2-Pack
SIG: 150 mg (1 mL) subcutaneously every 2 weeks Qty ____ Refills ____
☐ 150 mg/mL Pre-Filled Pen 2-Pack
SIG: 300 mg (2X150 mg/mL) subcutaneously every 4 weeks (monthly) Qty ____ Refills ____
Prescription type: ☐ New Start ☐ Reauthorization ☐ Continuation (new insurance)

Sharps container 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 ______

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 request MyPRALUENT (the "Program") to conduct a benefits 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.

SECTION 4 - Coverage Support (please indicate your preferred specialty pharmacy)

Preferred Specialty Pharmacy Name[a] ____________
Phone ____________ Fax ____________

☐ By checking the box, I understand MyPRALUENT will confirm that the specialty pharmacy listed above will be able to service the prescription. The specialty pharmacy will be responsible for securing any coverage, including prior authorization support, on my patient's behalf.

[a]While you may select any specialty pharmacy, please note that each specialty pharmacy may require its own intake form in addition to the MyPRALUENT Enrollment Form. Your selected specialty pharmacy may not be in the health plan's network. MyPRALUENT will inform you of the specialty pharmacies in the health plan's network and whether the health plan mandates the use of particular specialty pharmacies. MyPRALUENT will transmit the prescription to a pharmacy in the health plan's designated network or that is mandated by the health plan. However, if this prescription is not so designated, MyPRALUENT will transmit the prescription to the pharmacy indicated on this form or, if none is indicated, to a network pharmacy it selects.

Please click here for full Prescribing Information.

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

Complete the MyPRALUENT® Enrollment Form and fax all 4 pages and all supporting documentation to MyPRALUENT at 1-844-872-5447.

For MyPRALUENT use only: Patient ID ____________ Trans ID ____________

PRESCRIBER TO FILL OUT

Patient Name ____________ **Prescriber Name** ____________ **NPI #** ____________

SECTION 5 - Treatment Information

ICD-10 Diagnosis Codes

Select at least one primary and one secondary ICD-10 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 as a primary diagnosis, 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 Disease	☐ I21.__ ☐ I22.__ ☐ I23.__
Chronic Ischemic Heart Disease	☐ I25.__
Cerebrovascular Diseases	☐ I63.__ ☐ I65.__ ☐ I66.__ ☐ I67.__
Atherosclerosis	☐ I70.__
Other Peripheral Vascular Diseases	☐ I73.__
Other	☐ ___.__ ☐ ___.__

History of ASCVD event

☐ None ☐ Yes (please indicate below)

Date: mm/yy ____________

- ☐ Angina
- ☐ Myocardial Infarction
- ☐ Transient Ischemic Attack
- ☐ Percutaneous Transluminal Coronary Angioplasty
- ☐ Peripheral Artery Disease
- ☐ Stroke
- ☐ Coronary or Other Arterial Revascularization

LDL-C Values:

Current LDL-C ______ mg/dL Date: mm/yy ______

Previous and/or Current Lipid-Lowering Treatments

☐ None ☐ Yes (please indicate below)

	Dose	Start date	Stop date	Intolerant	Current
☐ atorvastatin	______	______	______	☐	☐
☐ pravastatin	______	______	______	☐	☐
☐ rosuvastatin	______	______	______	☐	☐
☐ simvastatin	______	______	______	☐	☐
☐ ezetimibe	______	______	______	☐	☐
☐ Other ______				☐	☐
☐ Other ______				☐	☐

Last date on lipid-lowering treatment: mm/dd/yyyy ____________

☐ Failure on or contraindications to any of the above therapies? ____________

☐ Lifestyle modifications (eg, exercise, diet) ____________

☐ Consultation with specialist (eg, cardiologist, lipidologist) ____________

SECTION 6 - Financial Assistance Information

☐ Check this box to learn more about options for patients who need assistance with out-of-pocket costs for PRALUENT.

Please click here for full Prescribing Information.

For MyPRALUENT use only: Patient ID ____________________ Trans ID ______________________

Patient Name ______________________ **Prescriber Name** ______________________ **NPI #** ______________________

SECTION 7 - 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), ("My Information") for the following purposes:

- to determine if I am eligible to participate in MyPRALUENT coverage assistance programs, patient assistance programs, or other support programs (the "Program")
- to investigate my health insurance coverage for PRALUENT 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 MyPRALUENT at 4700 Millenia Blvd, Suite 500, Orlando, FL 32839; Fax: 1-844-872-5447. 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 and fax all 4 pages and all supporting documentation to MyPRALUENT at 1-844-872-5447.

Please click here for full Prescribing Information.

For MyPRALUENT use only: Patient ID ____________________ Trans ID ______________________

Patient Name ______________________ **Prescriber Name** ______________________ **NPI #** ____________________

SECTION 8 - Patient Certifications (please read the following carefully, then date and sign where indicated in section 1 of page 1)

I am enrolling in the **MyPRALUENT**® 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 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.

I authorize the Alliance to contact me by mail, telephone, or email, or, if I indicate my agreement and consent below, by text, with information about the Program, my condition, 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, in the event that I report an adverse event, Sanofi may contact me to conduct a routine adverse event follow-up.

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, 4700 Millenia Blvd, Suite 500, Orlando, FL 32839. I also understand that the Services may be revised, changed, or terminated at any time.

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 from future text messages at any time by texting STOP to 64034 from my mobile phone, and that I can get help for text messages by texting HELP to 64034. 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 I may be contacted by Sanofi in the event I reported an adverse event through SMS/text messages. 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.

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

Complete and fax all 4 pages and all supporting documentation to MyPRALUENT at 1-844-872-5447.

Please click here for full Prescribing Information.

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