PRALUENT® (alirocumab) Patient Assistance Program (PAP) Re-enrollment Form

If you need help paying for your medicine, MyPRALUENT may be able to help eligible patients. 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:

✓ PRALUENT injection 75 mg/mL, 150 mg/mL

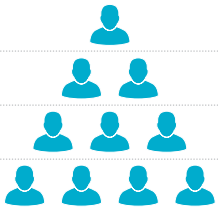
Your insurance ✓ I am uninsured or insured with no pharmacy coverage

Previous enrollment ✓ I have been previously enrolled in MyPRALUENT PAP

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 PAP if I have demonstrated my household income is no more than 300% of the federal poverty level (FPL), shown in the chart below*,†

Income eligibility requirements

Number of people in your household	Maximum income level to qualify for PAP (300% of the FPL)
	$46,950 for a household of 1
	$63,450 for a household of 2
	$79,950 for a household of 3
	$96,450 for a household of 4
For households exceeding 4 members, add $16,500 for each additional member to the $96,450 referenced above.	

*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. MyPRALUENT may revise, change, or terminate this program at any time without notice.

†Calculations are for residents of the 48 contiguous United States and the District of Columbia. Residents of Alaska, Hawaii, or Puerto Rico should contact MyPRALUENT to verify income criteria. All patients are subject to a soft credit check prior to approval. Proof of income may be required.

Re-enrolling in the MyPRALUENT Patient Assistance Program

Option 1 (for quicker processing): Visit **www.PRALUENT.com** to re-enroll online

Option 2: Complete this Re-enrollment Form then fax or mail to MyPRALUENT

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 complete and 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-PRALUENT (1-844-772-5836), Option 1

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

Please see accompanying full Prescribing Information or visit www.PRALUENT.com.

For internal 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

OK to Send Text Message? ☐ Yes ☐ No
By checking "Yes," I indicate that I have read the Text Messaging Consent in Section 6 and expressly consent to receive text messages by or on behalf of the Program

Email _____

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 Email** _____ **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 re-enrollment in the MyPRALUENT® Patient Assistance Program.**

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., and its affiliates and agents (together, "Regeneron") 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 to otherwise administer the product prescribed for the patient. 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 for purposes of conducting an investigation of my patient's health insurance coverage benefits for the product prescribed for the patient. I request that MyPRALUENT conduct a benefit investigation for my patient and I authorize MyPRALUENT 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 MyPRALUENT may revise, change, or terminate any program services at any time without notice to me.

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

_____
Supervising Prescriber Name
(If applicable)

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

Rx Information: PRALUENT® (alirocumab) injection

Established CV disease or primary hyperlipidemia (including HeFH):

☐ 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**_____

HeFH undergoing LDL apheresis or HoFH

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

Drug Allergies _____ ☐ NKDA

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

ICD-10-CM Diagnosis Codes

Select at least 1 primary and 1 secondary ICD-10-CM code.

Primary diagnosis (MUST select at least 1)

☐ E78.0 (Pure hypercholesterolemia, including HeFH and HoFH)
☐ 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 ☐ __. _ _

CV=cardiovascular; HeFH=heterozygous familial hypercholesterolemia; HoFH=homozygous familial hypercholesterolemia; ICD-10-CM=*International Classification of Diseases, Tenth Revision, Clinical Modification*; LDL=low-density lipoprotein; NKDA=no known drug allergies; NPI=National Provider Identifier; SIG=directions for use.

For additional assistance, call us at 1-844-PRALUENT (1-844-772-5836), Option 1

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

Please see accompanying full Prescribing Information or visit www.PRALUENT.com.

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SECTION 3 Household 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. Include income from your spouse and any supplemental income from investments and/or real estate.

To qualify for the MyPRALUENT® Patient Assistance Program, I understand that I must have been previously enrolled in the program, be uninsured or insured with no pharmacy coverage, and meet income requirements. Continuation in the program is conditioned upon timely verification of income. In addition, I agree to notify MyPRALUENT if my insurance situation changes, and I understand that such a change could impact my eligibility for the Patient Assistance Program.

SECTION 4 Health Insurance Status

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

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

Do you have Medicare Part A or Part B? ☐ Yes ☐ No ☐ Pending

If yes, what is your Medicare effective date? ___/___/___
MM / DD / YYYY

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

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 Veterans 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 internal use only: Patient ID _____ Trans ID _____

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

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

Authorization to Disclose Information:

I authorize my healthcare providers and staff (together, Healthcare Providers), my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies ("Specialty Pharmacies") that dispense my medication to disclose to Regeneron 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 MyPRALUENT Patient Assistance Program Re-enrollment 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 Regeneron medications that I have been prescribed
- To 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, Regeneron 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 Pharmacies may receive remuneration from Regeneron in exchange for disclosing My Information to Regeneron and/or for providing me with support services for Regeneron medications
- Once My Information has been disclosed to Regeneron, I understand that federal privacy laws may no longer protect it from further disclosure. However, Regeneron has agreed 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 Regeneron medications outside of the Program

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 Regeneron, by mailing or faxing a written request to Regeneron at PO Box 592188, Orlando, FL 32859-2188; 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.

(continued on next page)

For internal use only: Patient ID _____ Trans ID _____

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

Patient Certification:

I understand that completing the Program Re-enrollment Form is not a guarantee of eligibility for the Program.

I also understand that Regeneron may change or discontinue the Program at any time without notice.

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

I also certify that:

- The information I provided on the Program Re-enrollment Form is complete and accurate
- I will not request reimbursement from any insurance carrier or government health benefit program for Regeneron 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 in a Medicare Part D plan, I will inform the Program immediately by calling 1-844-PRALUENT (1-844-772-5836)

Text Messaging Consent:

I acknowledge that by checking the Text Messaging Consent box in Section 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 Regeneron 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 STOP to 1-407-891-4487 from my mobile phone, and that I can get help for text messages by texting HELP to 1-407-891-4487. 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. Message and data rates may apply. I understand that my consent is not required as a condition of purchasing any goods or services from Regeneron or its affiliates.

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)

REGENERON®