DUPIXENT myway®

# Enrollment Form

***Complete entire form and fax ALL 4 PAGES to DUPIXENT MyWay® at 1-844-387-9370.***
To prevent delays, complete the entire form and fax it to the number above. For assistance, call **1-844-DUPIXEN(T) (1-844-387-4936) Option 1**, Monday–Friday, 8 AM–9 PM Eastern time.

Respiratory

Patient to Fill Out

## Section 1. Patient Information

Patient name (first, MI, last) _____ DOB _____ Gender ☐ F ☐ M
Address _____ City _____
State _____ ZIP _____ Preferred patient language (if not English) _____

**Mobile phone** (_____)_____ ☐ Preferred # ☐ Voicemail **Alternate phone** (_____)_____ ☐ Preferred # ☐ Voicemail
Best time to call ☐ 8–10 AM ☐ 10 AM–12 PM ☐ 12–2 PM ☐ 2–4 PM ☐ 4–6 PM ☐ 6–9 PM
**Email** _____
☐ **I have read the Text Messaging Consent in Section 8 and expressly consent to receive text messages by or on behalf of the Program.**

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

Sign _____
(1 of 2) **Patient signature/Legal representative if patient is <18 years** Date
Printed name if signed by legal representative if patient is <18 years

I have read and agree to the Patient Certifications included in Section 8.

Sign _____
(2 of 2) **Patient signature/Legal representative if patient is <18 years** Date
Representative relationship to patient if patient is <18 years

Prescriber to Fill Out

## Section 2. Insurance Information

☐ No insurance *(Fill out Section 6 if you do not have health insurance.)* ☐ *Attached copies of front and back of primary medical and prescription cards.*

**Primary medical** insurance name _____
Insurance phone (_____) _____
Policy ID # _____ Group # _____
Policyholder name (first/last) _____
Relationship to patient _____

**Primary Rx** insurance name (if different) _____
**Rx** insurance phone (_____) _____
Policy ID # _____ Group # _____
Rx BIN # _____ Rx PCN # _____

☐ **I have already sent this prescription to the specialty pharmacy.**
By checking the box, I acknowledge *DUPIXENT MyWay* will not conduct a benefits verification. The specialty pharmacy is responsible for securing coverage on my patient's behalf.
My preferred specialty pharmacy is _____ Phone (_____) _____ Fax (_____) _____

## Section 3. Prescriber Information

Prescriber name _____
Prescriber NPI # _____
Specialty _____
Address _____
City _____ State _____ ZIP _____

Site/facility name _____
Office contact name _____
Office contact email _____
Phone (_____) _____
Fax (_____) _____

## Section 4. Diagnosis (Complete ONE diagnosis only)

Date of diagnosis _____/_____/_____

*See the list of potential ICD-10-CM codes on page 2.*
*Attach any chart notes relevant to diagnosis and current/prior therapies.*

**Moderate-to-severe asthma with eosinophilic phenotype or oral corticosteroid dependent asthma**
☐ Primary diagnosis
**ICD-10-CM code(s):**
☐ **J45.50** Severe persistent asthma, uncomplicated ☐ Oral corticosteroid-dependent
☐ **J45.40** Moderate persistent asthma, uncomplicated ☐ Eosinophilic phenotype
☐ Other _____

**Chronic rhinosinusitis with nasal polyposis**
☐ Primary diagnosis
**ICD-10-CM code(s):**
☐ **J33.9** Nasal polyps, unspecified ☐ **J33.0** Polyp of nasal cavity
☐ Other _____

Please see full indications on next page. ICD-10-CM=*International Classification of Diseases, Tenth Revision, Clinical Modification.*

## Section 5a. Prescription Information

Prescription: ☐ New start ☐ Sample product provided Date _____/_____/_____

**Moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma**
**Rx: DUPIXENT® (dupilumab), (200 mg/1.14 mL, 300 mg/2 mL)**
Known drug allergies _____
Pre-filled **syringe**, package of 2
☐ **Initial dose:** 400 mg SIG: 2 (200 mg/1.14 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 200 mg
SIG: 1 (200 mg/1.14 mL) injection SQ every 2 weeks, starting on Day 15
OR
☐ Pre-filled **syringe**, package of 2 **OR** ☐ Pre-filled **pen**, package of 2
☐ **Initial dose:** 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15
OR
☐ **Subsequent (maintenance):** Other
Dose _____ SIG _____
**Qty: 1 pk (2 syringes or 2 pens)** **Refills** _____ **Days' supply:** ☐ 30

**Chronic rhinosinusitis with nasal polyposis**
**Rx: DUPIXENT® (dupilumab), (300 mg/2 mL)**
Known drug allergies _____
☐ Pre-filled **syringe**, package of 2 **OR** ☐ Pre-filled **pen**, package of 2
☐ **Dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks
OR
☐ Other
Dose _____ SIG _____
**Qty: 1 pk (2 syringes or 2 pens)** **Refills** _____ **Days' supply:** ☐ 30

**Collaborating MD name** _____
(Nurse practitioner/physician assistant)
**NPI #** _____

**The DUPIXENT® (dupilumab) Quick Start Program may be able to provide DUPIXENT at no cost if an eligible, commercially insured patient experiences a coverage delay.**
**See Section 5b on page 2 for information about the DUPIXENT Quick Start Program.**

Sign _____
Prescriber signature (No stamps) **Dispense as written** Date

OR

Sign _____
Prescriber signature (No stamps) **Substitution permitted** Date

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; that therapy with DUPIXENT is medically necessary; and that I have prescribed DUPIXENT to the patient named on this form for an FDA-approved indication. 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 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 *DUPIXENT MyWay* for these purposes. If applicable, I authorize *DUPIXENT MyWay* to conduct a benefits investigation for my patient and 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 provided that, 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 otherwise indicated. I understand that any free product distributed through the *DUPIXENT MyWay* Patient Assistance Program is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. I consent to *DUPIXENT MyWay* contacting me by fax, mail, or email to provide additional information about DUPIXENT injection or *DUPIXENT MyWay*. I understand that *DUPIXENT MyWay* may revise, change, or terminate any program services at any time without notice to me.

**If you are a New York prescriber, please use an original New York State prescription form. The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.**



**Please see accompanying full Prescribing Information or visit DUPIXENThcp.com.**

DUPIXENT® (dupilumab) Injection
200mg · 300mg

DUPIXENT myway

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Respiratory

**Patient Name** **DOB**

**Prescriber Name** **NPI #**

Prescriber to Fill Out

## Section 5b. DUPIXENT® (dupilumab) Quick Start Program

Complete page 1 of the Enrollment Form as well as this Rx and sign below for *DUPIXENT MyWay* to determine patient eligibility for a temporary supply of DUPIXENT in the event your patient experiences a coverage delay.

**Moderate-to-severe asthma with an eosinophilic phenotype or oral corticosteroid dependent asthma**

**Rx: DUPIXENT® (dupilumab), (200 mg/1.14 mL, 300 mg/2 mL)**

Known drug allergies _____

Pre-filled **syringe**, package of 2

☐ **Initial dose:** 400 mg SIG: 2 (200 mg/1.14 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 200 mg
SIG: 1 (200 mg/1.14 mL) injection SQ every 2 weeks, starting on Day 15

OR

☐ Pre-filled **syringe**, package of 2 **OR** ☐ Pre-filled **pen**, package of 2
☐ **Initial dose:** 600 mg SIG: 2 (300 mg/2 mL) injections SQ on Day 1
☐ **Subsequent (maintenance) dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks, starting on Day 15

OR

☐ **Subsequent (maintenance):** Other
Dose _____ SIG _____

**Qty: 1 pk (2 syringes or 2 pens)** **Refills** _____ **Days' supply:** ☐ 30

**Chronic rhinosinusitis with nasal polyposis**

**Rx: DUPIXENT® (dupilumab), (300 mg/2 mL)**

Known drug allergies _____

☐ Pre-filled **syringe**, package of 2 **OR** ☐ Pre-filled **pen**, package of 2
☐ **Dose:** 300 mg
SIG: 1 (300 mg/2 mL) injection SQ every 2 weeks

OR

☐ Other
Dose _____ SIG _____

**Qty: 1 pk (2 syringes or 2 pens)** **Refills** _____ **Days' supply:** ☐ 30

**Collaborating MD name** _____
(Nurse practitioner/physician assistant)
**NPI #** _____

Sign _____
Prescriber signature (No stamps) Dispense as written Date

OR

Sign _____
Prescriber signature (No stamps) Substitution permitted Date

I authorize for my commercially insured patient one or more months of temporary shipments of DUPIXENT during a benefits determination delay or during the appeal process after an initial coverage delay for DUPIXENT by the patient's insurer. I authorize *DUPIXENT MyWay* to forward this prescription to the pharmacy dispensing the DUPIXENT Quick Start Program product to the patient named herein. I agree to assist in efforts to secure access to DUPIXENT for my commercially insured patient in the event of a coverage delay.

**If you are a New York prescriber, please use an original New York State prescription form. The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.**

Patient to Fill Out

## Section 6. Household Income

### *Patient to Fill Out*

Required if enrolling in the *DUPIXENT MyWay®* Patient Assistance Program

How many people live in your household? _____

What is your total annual household income? _____
(Includes salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.)

I certify that the number of people in my household and my household income provided above are true and accurate to the best of my knowledge. I agree that Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together, the "Alliance") may verify my eligibility for the *DUPIXENT MyWay* Patient Assistance Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional financial, insurance, and/or medical information. I authorize the Alliance to use my 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. I further understand and authorize the Alliance to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the Patient Assistance Program eligibility determination process, if applicable. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. Continuation in the *DUPIXENT MyWay* Patient Assistance Program is conditioned upon timely verification of income. In addition, I agree to notify *DUPIXENT MyWay* if my insurance situation changes.

## INDICATIONS

**Asthma:** DUPIXENT® (dupilumab) is indicated as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma.

Limitation of Use: DUPIXENT is not indicated for the relief of acute bronchospasm or status asthmaticus.

**Chronic rhinosinusitis with nasal polyposis (CRSwNP):** DUPIXENT is indicated as an add-on maintenance treatment in adult patients with inadequately controlled CRSwNP.

## List of potential ICD-10-CM codes

### Moderate-to-severe asthma with eosinophilic phenotype or oral corticosteroid dependent asthma

- **J45.4** (Moderate persistent asthma)
- **J45.5** (Severe persistent asthma)
- **J45.9** (Other and unspecified asthma)
- **J45.40** (Moderate persistent asthma, uncomplicated)
- **J45.50** (Severe persistent asthma, uncomplicated)
- **J45.90** (Unspecified asthma)
- **J45.41** (Moderate persistent asthma with [acute] exacerbation)
- **J45.51** (Severe persistent asthma with [acute] exacerbation)
- **J45.901** (Unspecified asthma with [acute] exacerbation)

### Chronic rhinosinusitis with nasal polyposis

- **J33** (Nasal polyp)
- **J33.8** (Other polyp of sinus)
- **J33.0** (Polyp of the nasal cavity)
- **J33.9** (Nasal polyp, unspecified)
- **J33.1** (Polypoid sinus degeneration)

This coding information is provided for informational purposes only and is subject to change. These codes may not apply to all patients or to all health plans; providers must exercise independent judgment when selecting codes and submit claims that accurately reflect the diagnoses of a specific patient.

**Patient Name** **DOB**

**Prescriber Name** **NPI#**

Section 7. **Authorization to Use and Disclose Health Information**

***Patient:* Please read the following carefully, then date and sign where indicated in *Section 1* on page 1**

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 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, and prescription (including fill/refill information) related to my prescription for DUPIXENT® (dupilumab) therapy ("My Information"). I understand the disclosure to the Alliance will be for the purposes of enrolling me in, and providing certain services through the "*DUPIXENT MyWay*® Program," including:

- to determine if I am eligible to participate in *DUPIXENT MyWay* coverage assistance programs, patient assistance programs, or other support programs
- 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 *DUPIXENT MyWay* 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 that the Alliance may de-identify My Information and use it in performing research, education, business analytics, marketing studies, or for other commercial purposes, including linkage with other de-identified information the Alliance receives from other sources. I understand that members of the Alliance may share My Information, including identifiable health information, among themselves in order to de-identify it for these purposes and as needed to perform the Services or to communicate with me by mail, telephone, or e-mail, or, if I indicate my agreement and consent in Section 1 on page 1, by text. I understand and agree that the Alliance may use My Information for these purposes and may share My Information with my Healthcare Providers, Health Insurers and Specialty Pharmacies.
  - I understand and agree that my Healthcare Providers, Health Insurers, and Specialty Pharmacies 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 *DUPIXENT MyWay* 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, I also understand the Alliance 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. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, payment for treatment, insurance coverage, access to health benefits or Alliance medications from covered entities such as Health Care Providers, Health Insurers, and Specialty Pharmacies. However, if I do not sign this Authorization, I understand that I will not be able to participate in the *DUPIXENT MyWay* Program.

I understand that this Authorization expires 18 months from the date support is last provided under the Program, or until my local state law requires expiration, subject to applicable law, unless and until I withdraw (take back) this Authorization before then, or as otherwise required by law. 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 *DUPIXENT MyWay* 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, Health Insurers, and Specialty Pharmacies.

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

**Patient Name** **DOB**

**Prescriber Name** **NPI#**

Section 8. **Patient Certifications**

***Patient: Please read the following carefully, then date and sign where indicated in Section 1 on 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").

If enrolling in the *DUPIXENT MyWay* Copay Card Program, I understand that Copay Card information will be sent to my designated specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or copayment for DUPIXENT® (dupilumab) 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 information I have set forth in Section 6, including my household income, is 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,[a] with information about the Program, disease state and products, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys (together, the "Communications"). I understand that I may be contacted by the Alliance in the event that I report an adverse event.

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 Healthcare Provider. 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.

## Other Information About Privacy Practices

I understand that my health information, contact information, and other information I, my healthcare provider, and others share with Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together the "Alliance") is collected to provide me with the assistance I request and for other business purposes of the Alliance, as described in their privacy policy, which is available at regeneron.com/privacy-policy. Depending on where I live, I may have certain rights with respect to my privacy information, including the request to access or delete my personal information. I am aware that Regeneron may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact the Privacy Office by emailing dataprotection@regeneron.com or by calling 844-835-4137. I may reference Sanofi's Global Privacy Policy at sanofi.com/our-responsibility/sanofi-global-privacy-policy for further information regarding these rights with respect to Sanofi US.

## Text Messaging Consent:

[a]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. 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 Pharmaceuticals, Inc., Sanofi US, or their affiliates.

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