DUPIXENT myway | DUPIXENT (dupilumab) Injection

# *DUPIXENT MyWay* Enrollment Form

**By completing this form,** you are enrolling your patient into *DUPIXENT MyWay*, a patient support program that provides financial assistance, coverage support, and resources throughout a patient's journey with DUPIXENT.

**HOW TO SUBMIT**

**Send all pages and insurance information via**
**Fax:** 1-844-387-9370 or
**Electronic upload:** Scan QR code or visit DUPIXENTMyWayPortal.com *(code: 8443879370)*

## 1 PATIENT INFORMATION

**If patient <18 (Puerto Rico <21), provide contact information of legal representative*

| | | | |
|---|---|---|---|
| Name *(First MI Last)* | | DOB *(MM/DD/YYYY)* | |
| Sex assigned at birth ☐ Female ☐ Male | Language *(if not English)* | | |
| Address *(no PO Box)* | City | State | ZIP |
| Email* | Phone* | ☐ Voicemail OK? | |

**Caregiver or authorized contact information** *(optional)* ☐ I consent for the program to contact the following person

| | | |
|---|---|---|
| Contact name | Relationship | |
| Email | Phone | ☐ Voicemail OK? |

**Patient authorizations -** *Both signatures are required below*

☐ 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/legal representative if patient is <18 years (Puerto Rico <21)

DATE

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

SIGN

Patient/legal representative if patient is <18 years (Puerto Rico <21)

DATE

**SCAN** to add *DUPIXENT MyWay* to your contacts

| | | |
|---|---|---|
| If signed by legal representative: | Printed name | Relationship |

## 2 INSURANCE INFORMATION

☐ I have included a copy of the patient's insurance cards *(front and back)* or information

☐ Patient has NO insurance

## 3 BENEFITS INVESTIGATION AND PRESCRIPTION FULFILLMENT

**Benefits investigation**

☐ I would like *DUPIXENT MyWay* to provide a Summary of Benefits

**Prescription fulfillment**

☐ I would like *DUPIXENT MyWay* to triage the prescription to a payer-preferred specialty pharmacy

OR If *DUPIXENT MyWay* is **not triaging** the prescription, I have sent or will send this enrollment form (including the prescription in Section 6) to the specialty pharmacy listed below

| | |
|---|---|
| SP name | Phone |

By submitting this enrollment form, *DUPIXENT MyWay* will be able to view patient information and provide program support services and resources to eligible patients.

## 4 DIAGNOSIS - Moderate-to-severe eosinophilic or OCS-dependent asthma

**CHOOSE ONE** ICD-10 code or write in if not listed.

**Reminder:** Only FDA-approved indications are eligible for support. List of ICD-10 codes may not be exhaustive.

☐ J45.40 Moderate persistent asthma, uncomplicated
☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.51 Severe persistent asthma with (acute) exacerbation
☐ Other ☐☐☐.☐☐☐

AND

**CHOOSE ONE CHARACTERIZATION**

☐ Oral corticosteroid dependent
☐ Eosinophilic phenotype


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DUPIXENT myway | DUPIXENT (dupilumab) Injection

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**HOW TO SUBMIT**

**Send all pages and insurance information via**
**Fax:** 1-844-387-9370 or
**Electronic upload:** Scan QR code or visit DUPIXENTMyWayPortal.com *(code: 8443879370)*

| Patient name | DOB *(MM/DD/YYYY)* |
|---|---|

## 5 PRESCRIBER INFORMATION

| | | | |
|---|---|---|---|
| Prescriber name | | Specialty | |
| Address | | City | State / ZIP |
| Prescriber NPI # | Tax ID | Site/facility name | |
| Office contact name | | Office contact email | |
| Phone | Fax | Prescriber State Lic. # (Puerto Rico only) | |

## 6 RX: DUPIXENT® (DUPILUMAB) (200 MG/1.14 ML OR 300 MG/2 ML) PRESCRIPTION

**Complete the prescription and sign where indicated.**

**Preferred device type:**

- ☐ **Pre-filled syringe**
- OR
- ☐ **Pre-filled pen**

| Refills | Weight *(kg)* | 1 kg = 2.2 lbs |
|---|---|---|

Known drug allergies

**Loading dose quantity:** *quantity sufficient for 1 loading dose*

**Subsequent dose quantity:** *quantity sufficient up to 84-day supply for every 2-week dosing or up to 56-day supply for every 4-week dosing*

**Prescriber signatures** *(NO stamps)*

Dispense as written

SIGN

DATE

OR

Substitutions permitted

SIGN

DATE

Collaborating MD name

NPI #

**ADULT AND PEDIATRIC DOSING**

| AGE | CONSIDERATIONS | WEIGHT | DOSING |
|---|---|---|---|
| ≥12 years | N/A | N/A | ☐ **Loading dose:** 400 mg SIG: 2 (200 mg/1.14 mL) subQ on Day 1<br>☐ **Subsequent dose:** 200 mg SIG: 1 (200 mg/1.14 mL) subQ every 2 weeks, start on Day 15 |
| | | | ☐ **Loading dose:** 600 mg SIG: 2 (300 mg/2 mL) subQ on Day 1<br>☐ **Subsequent dose:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 2 weeks, start on Day 15 |
| | OCS-dependent asthma<br>OR<br>Co-morbid moderate-to-severe atopic dermatitis<br>Co-morbid chronic rhinosinusitis with nasal polyps<br>Co-morbid allergic fungal rhinosinusitis* | N/A | ☐ **Loading dose:** 600 mg SIG: 2 (300 mg/2 mL) subQ on Day 1<br>☐ **Subsequent dose:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 2 weeks, start on Day 15<br>**for pediatric patients 12 years to 17 years of age (≥60 kg) and adults with AFRS* |
| 6–11 years | N/A | 15 kg–<30 kg | ☐ **Initial and subsequent doses:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 4 weeks |
| | | ≥30 kg | ☐ **Initial and subsequent doses:** 200 mg SIG: 1 (200 mg/1.14 mL) subQ every 2 weeks |
| | Asthma<br>AND<br>Co-morbid moderate to-severe atopic dermatitis | 15 kg–<30 kg | ☐ **Loading dose:** 600 mg SIG: 2 (300 mg/2 mL) subQ on Day 1<br>☐ **Subsequent dose:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 4 weeks, start on Day 29 |
| | | 30 kg–<60 kg | ☐ **Loading dose:** 400 mg SIG: 2 (200 mg/1.14 mL) subQ on Day 1<br>☐ **Subsequent dose:** 200 mg SIG: 1 (200 mg/1.14 mL) subQ every 2 weeks, start on Day 15 |
| | | ≥60 kg | ☐ **Loading dose:** 600 mg SIG: 2 (300 mg/2 mL) subQ on Day 1<br>☐ **Subsequent dose:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 2 weeks, start on Day 15 |

**Prescriber Certification:** 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 facilitate the filling of my patient's prescription; 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 *DUPIXENT MyWay* for these purposes and for the purposes set forth in Section 7. Further, I have discussed and confirmed the patient's agreement that they would like to receive the Services and Communications set forth in Section 8. 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.**


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# *DUPIXENT MyWay* Enrollment Form

**PATIENT**
Please read the following carefully, then sign and date where indicated in Section 1 on Page 1

## 7 PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH 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 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 also authorize my Healthcare Providers, Health Insurers, Specialty Pharmacies and the Alliance to use My Information and share it with each other for the purposes described below. I understand that my Healthcare Providers, Health Insurers, Specialty Pharmacies and the Alliance will receive, use, and disclose My Information 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 communicate with me by mail, telephone, or email (or text message, if consented) regarding the Program, disease state and product-related education and services, information about my participation in the Program and treatment, and to evaluate and improve the Program and associated services provided, as set forth in Section 8; and
- to refer me to, or to determine my eligibility for, other programs, or alternative sources of funding or coverage that may be available to provide assistance to me with the costs of my medication.

In support of the purposes above, the Alliance may de-identify My information and use it in performing research, education, business analytics, and marketing studies, and also 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 email, 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 five years from the date of my signature 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. For patients with Maryland healthcare providers, this authorization expires 1 year from the date of signature. Further, I understand that I may withdraw this Authorization at any time by mailing or faxing a written request to *DUPIXENT MyWay* at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067; 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.**

## 8 PATIENT CONSENT AND CERTIFICATIONS

***DUPIXENT MyWay* Program Enrollment Consent.** 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.

**Credit Check Consent.** I authorize the Alliance to 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 under the Fair Credit Reporting Act 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.


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# *DUPIXENT MyWay* Enrollment Form

**PATIENT**
Please read the following carefully, then sign and date where indicated in Section 1 on Page 1

## 8 PATIENT CONSENT AND CERTIFICATIONS (CONTINUED)

**Conditions of Participation.** 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. If approved for the *DUPIXENT MyWay* Patient Assistance Program, I will not seek to have the value of any medication provided to me under this program counted toward my true-out-of-pocket (TrOOP) cost for prescription drugs for my Medicare Part D Plan. 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.

Patients whose health insurance benefits offer, or whose health insurance plans work with, an alternative funding program are not eligible for the Alliance *DUPIXENT MyWay* Patient Assistance Program/need-based free drug. "Alternative funding programs" sometimes refer to themselves with different names and promote their services as a benefit being offered through patients' health insurance plans. In determining whether your health insurance plan offers or works with an alternative funding program, please consider the following: (1) did a third party assist you with, or provide guidance about, the preparation of your application for this program and/or direct you to apply; (2) were you told that you were required to work with a third party or a "patient advocate" in order to receive coverage for your medicine; (3) were you told that you were required to apply to a manufacturer's patient assistance program as a prerequisite to having plan coverage for your specialty drug, including Alliance products; (4) were you told that you do not have plan coverage for your specialty drug unless alternative funding sources for your specialty drug could not be found, (5) were you required by your plan to provide personal and health information to a third party program or enter such information into a third party patient portal in advance of completing this application, (6) did your employer recently tell you that your specialty drug plan benefits have changed; or (7) do you have any other reason to think that your health plan may work with an alternative funding program, or an alternative funding program may be involved in your plan benefits? If you answered yes to any of these questions, please check with your plan sponsor and review your plan benefits to determine whether your plan works with a third party that provides any of the services, or is connected to any of the requirements described herein. If it does, you are not eligible to apply for this program. By applying to the *DUPIXENT MyWay* Patient Assistance Program, you certify that the answer to all of these questions is "no."

I also understand that the Services may be revised, changed, or terminated at any time and that the Program may be changed or discontinued without notice.

**Communications Consent.** I authorize the Alliance to communicate with me by mail, telephone, or email, or, if I indicate my agreement and consent on page 1, by text,* regarding the Program, disease state and product-related education and services, information about my participation in the Program and treatment, and to evaluate and improve the Program and associated services provided (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 understand that Communications transmitted via unencrypted email or text message over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner. 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, by sending a letter to *DUPIXENT MyWay* 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067, or by contacting either Regeneron at DataProtection@Regeneron.com or Sanofi at PrivacyOfficeUSA@sanofi.com.

**Use of Personal and Sensitive Information Consent.** I understand that my health information, contact information, and other personal 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, for the purposes described in this Program Enrollment Form, and for other business purposes of the Alliance, as described in Regeneron's Privacy Notice, available at regeneron.com/privacy-policy; Regeneron's Consumer Health Data Privacy Policy, available at regeneron.com/privacy-policy; and Sanofi's US Global Privacy Policy, available at sanofi.com/our-responsibility/sanofi-global-privacy-policy. Further, I understand that my consent is required to process my sensitive information under certain U.S. state privacy laws, and by signing where indicated on page 1, I consent to the collection, use, disclosure, and processing of my personal and sensitive information, including my personal health data as described in the Alliance's privacy policies. I understand that I have the right to withdraw my consent at any time by notifying the Alliance using the contact information below. Depending on where I live, I may have certain rights with respect to my personal information, including the request to access or delete my personal information. I am aware that the Alliance may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact Regeneron's Privacy Office by emailing dataprotection@regeneron.com or by calling 1-844-835-4137 or Sanofi's Privacy Office at PrivacyOfficeUSA@sanofi.com.

**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 of future text messages at any time by texting STOP to 94742 from my mobile phone, and that I can get help for text messages by texting HELP to 94742. 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 participating in the Program, or 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.**


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To have your patient evaluated for the *DUPIXENT MyWay* Quick Start Program, complete this page and submit along with the completed Enrollment Form. This page cannot be submitted separately.

DUPIXENT myway | DUPIXENT® (dupilumab) Injection

# Optional - Quick Start Program

**FOR COMMERCIALLY INSURED PATIENTS ONLY:** The Quick Start Program may be able to temporarily provide DUPIXENT at no cost to help bridge commercially insured patients to therapy if there is a coverage delay. You must continue to pursue insurance coverage for the patient for them to remain eligible for this program.

**Moderate-to-severe eosinophilic or OCS-dependent asthma**

| Patient name | DOB *(MM/DD/YYYY)* |
|---|---|

## PRESCRIBER INFORMATION

| Prescriber name | | Prescriber NPI # | |
|---|---|---|---|
| Address | City | State | ZIP |
| Phone | Fax | Prescriber State Lic. # (Puerto Rico only) | |

## RX: DUPIXENT® (DUPILUMAB) (200 MG/1.14 ML OR 300 MG/2 ML) PRESCRIPTION

**Complete the prescription and sign where indicated.**

**Preferred device type:**

- ☐ **Pre-filled syringe**
- OR
- ☐ **Pre-filled pen**

Refills | Weight *(kg)* **1 kg = 2.2 lbs**

Known drug allergies

**Quantity sufficient up to a 28-day supply (or up to a 56-day supply for every 4-week dosing)**

**Prescriber signatures** *(NO stamps)*

Dispense as written

SIGN

DATE

OR

Substitutions permitted

SIGN

DATE

Collaborating MD name

NPI #

### ADULT AND PEDIATRIC DOSING

| AGE | CONSIDERATIONS | WEIGHT | DOSING |
|---|---|---|---|
| ≥12 years | N/A | N/A | ☐ **Loading dose:** 400 mg SIG: 2 (200 mg/1.14 mL) subQ on Day 1<br>☐ **Subsequent dose:** 200 mg SIG: 1 (200 mg/1.14 mL) subQ every 2 weeks, start on Day 15 |
| | | | ☐ **Loading dose:** 600 mg SIG: 2 (300 mg/2 mL) subQ on Day 1<br>☐ **Subsequent dose:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 2 weeks, start on Day 15 |
| | OCS-dependent asthma<br>OR<br>Co-morbid moderate-to-severe atopic dermatitis<br>Co-morbid chronic rhinosinusitis with nasal polyps<br>Co-morbid allergic fungal rhinosinusitis* | N/A | ☐ **Loading dose:** 600 mg SIG: 2 (300 mg/2 mL) subQ on Day 1<br>☐ **Subsequent dose:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 2 weeks, start on Day 15<br>**for pediatric patients 12 years to 17 years of age (≥60 kg) and adults with AFRS* |
| 6–11 years | N/A | 15 kg–<30 kg | ☐ **Initial and subsequent doses:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 4 weeks |
| | | ≥30 kg | ☐ **Initial and subsequent doses:** 200 mg SIG: 1 (200 mg/1.14 mL) subQ every 2 weeks |
| | Asthma<br>AND<br>Co-morbid moderate to-severe atopic dermatitis | 15 kg–<30 kg | ☐ **Loading dose:** 600 mg SIG: 2 (300 mg/2 mL) subQ on Day 1<br>☐ **Subsequent dose:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 4 weeks, start on Day 29 |
| | | 30 kg–<60 kg | ☐ **Loading dose:** 400 mg SIG: 2 (200 mg/1.14 mL) subQ on Day 1<br>☐ **Subsequent dose:** 200 mg SIG: 1 (200 mg/1.14 mL) subQ every 2 weeks, start on Day 15 |
| | | ≥60 kg | ☐ **Loading dose:** 600 mg SIG: 2 (300 mg/2 mL) subQ on Day 1<br>☐ **Subsequent dose:** 300 mg SIG: 1 (300 mg/2 mL) subQ every 2 weeks, start on Day 15 |

**Prescriber Certification:** 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 facilitate the filling of my patient's prescription; 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 *DUPIXENT MyWay* for these purposes and for the purposes set forth in Section 7. Further, I have discussed and confirmed the patient's agreement that they would like to receive the Services and Communications set forth in Section 8. 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 I am completing page 5, 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.**

sanofi | REGENERON®

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