



# Enrollment Form Instructional Guide

## A guide to successfully completing a DUPIXENT MyWay Enrollment Form

By completing an enrollment form, you are enrolling your patient into DUPIXENT MyWay, a patient support program that provides financial assistance, coverage support, and resources throughout their journey with DUPIXENT.

### HOW TO SUBMIT

Send all pages (1-5) and insurance information via:

**Fax 1-844-387-9370**

**Electronic upload DUPIXENTMyWayPortal.com**

code: 8443879370



Scan to upload electronically

If you need support, DUPIXENT MyWay is here to help.

Call 1-844-DUPIXENT (1-844-387-4936) Option 1, Monday–Friday, 8 am–9 pm ET



Submitting an Enrollment Form to DUPIXENT MyWay will not initiate a prior authorization—you will need to complete this separately, if required.

Indication name here

**DUPIXENT MyWay Enrollment Form**

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**

Name (First/Last) DOB (MM/DD/YYYY)

Sex assigned at birth:  Female  Male Language (if not English)

Address (no PO Box) City State ZIP

Email\* Phone\*  Voice/mail OK?

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

Contact name Relationship  Voice/mail OK?

Email Phone  Voice/mail OK?

Patient authorization - Both signatures are required below

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

SIGN (Patient/Authorized Representative) SIGN (Patient/Authorized Representative)

DATE DATE

SCAN QR code DUPIXENT MyWay to your contacts

**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 the DUPIXENT MyWay to provide a Summary of Benefits

Prescription fulfillment  I would like DUPIXENT MyWay to arrange the prescription to a payer-preferred specialty pharmacy  If DUPIXENT MyWay is not arranging the prescription, have sent or will send this enrollment form (including the prescription in Section 6) to the specialty pharmacy listed below

SP name Phone

**4. DIAGNOSIS - Indication name here**

CHOOSE ONE ICD-10 code or write in free space

L11.0 Diagnosis  L11.3 Diagnosis  L11.4 Diagnosis

L11.2 Diagnosis  Other

Healthcare ID# assigned  I have an ID# assigned  I do not have an ID# assigned

Use of ID#-3D codes may be restrictive

1 Please see accompanying full Prescribing Information or visit DUPIXENTMyWay.com. © 2025 Sanofi and Regeneron Pharmaceuticals, Inc. All Rights Reserved. US.DUP.25.10.0063 10/2025

PAGE 1

Indication name here

**DUPIXENT MyWay Enrollment Form**

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

**5. 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 and claims, and prescription information, and to provide information to the Alliance to use my information and share it with other parties for the purposes described below. I understand that my Health Insurers, Specialty Pharmacies, Health Insurers and 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 assist with approval of denied claims for coverage;
- for the operation and administration of the DUPIXENT MyWay Program;
- to communicate with my mail, telephone, or email for my message, if I 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 cost 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 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 Health Insurers, Specialty Pharmacies, Health Insurers and Specialty Pharmacies.

I understand and agree that my Health Insurers, 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 authorized 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 submit medical information, payment for treatment, insurance coverage, access to health benefits or Alliance membership 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, on, or as otherwise required by law, or as otherwise required by my healthcare provider. 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 sending a written request to DUPIXENT MyWay, 2725 S. Emerson St., Denver, CO 80202, Fax: 1-844-387-9370, without need for my signature. My withdrawal of this Authorization will end my participation in the DUPIXENT MyWay Program and will not affect my disclosure of My Information based on my Authorization made before my request to withdraw was received by my Healthcare Provider, Health Insurers, and Specialty Pharmacies.

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

**6. 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 communication and support, medication dispensing support, coverage and financial assistance education, disease and medication education, injection training, and other support services (the "Services"). If I enroll in the DUPIXENT MyWay Copy Card Program, I understand that Copy Card information will be sent to my designated specialty pharmacy along with my prescription, and my assistance with applicable state or federal laws for DUPIXENT 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 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 let me know whether an individual consumer report was requested and the name and address of the agency that furnished it. Further, I 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.

1 Please see accompanying full Prescribing Information or visit DUPIXENTMyWay.com. © 2025 Sanofi and Regeneron Pharmaceuticals, Inc. All Rights Reserved. US.DUP.25.10.0063 10/2025

PAGES 3 & 4

Indication name here

**DUPIXENT MyWay Enrollment Form**

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)

**5. PRESCRIBER INFORMATION**

Prescriber name Specialty

Address City State ZIP

Prescriber NPI # State/facility name

Office contact name Office contact email

Phone Fax Tax ID

**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  Pre-filled pen for use in indicated patients ≥2 years

Refills: Weight (kg) 1kg = 2.2lbs

Known drug allergies

Loading dose quantity: quantity sufficient for 1 loading dose

Subsequent dose quantity: quantity sufficient for 16-day supply for every 2-week dosing or up to 56-day supply for every 4-week dosing

Prescriber signature (NO stamp)

Dispense as written

Substitutions permitted

Collaborating MD name

NPI #

**DOSE:**

Age 18 years Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15

AGE WEIGHT DOSE:

Xg -<Kg Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks, start on Day 29

Xg -<Kg Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15

Xg -<Kg Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15

Xg -<Kg Initial and subsequent doses: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks

Xg -<Kg Initial and subsequent doses: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks

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PAGE 2

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.

**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.

Indication name here

**DUPIXENT MyWay Enrollment Form**

**5. PRESCRIBER INFORMATION**

Prescriber name Prescriber NPI #

Address City State ZIP

Phone Fax

**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  Pre-filled pen for use in indicated patients ≥2 years

Refills: Weight (kg) 1kg = 2.2lbs

Known drug allergies

Quantity sufficient up to a 28-day supply up to a 56-day supply for every 4-week dosing

Prescriber signature (NO stamp)

Dispense as written

Substitutions permitted

Collaborating MD name

NPI #

**DOSE:**

Age 18 years Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15

AGE WEIGHT DOSE:

Xg -<Kg Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks, start on Day 29

Xg -<Kg Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15

Xg -<Kg Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15

Xg -<Kg Initial and subsequent doses: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks

Xg -<Kg Initial and subsequent doses: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks

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PAGE 5 - QUICK START PROGRAM

**!** Select the indication-specific DUPIXENT MyWay Enrollment Form for your patient. You will find the indication at the top of the form.

**!** Make sure to fill out each section fully and accurately to avoid delays in processing the enrollment.  
**PAGE 1 must be completed for all patients.**

A physical address is required for shipping the medication. No PO Boxes.

Adding a caregiver or authorized contact is optional. Note that this person can differ from the legal representative.

The patient or their legal representative must sign and enter the current date in both signature fields within this section.

Indicate whether your office would like benefits investigation and/or prescription fulfillment support from *DUPIXENT MyWay*.

*Regardless of your selection, your patient can still receive program support services when a completed, signed enrollment form is submitted.*

Don't forget to include the specialty pharmacy's name and phone number if *DUPIXENT MyWay* is not triaging the prescription.

Indication name here

### 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](http://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

**4 DIAGNOSIS - Indication name here**

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

L11.0 Diagnosis

L11.1 Diagnosis

L11.2 Diagnosis

L11.3 Diagnosis

L11.4 Diagnosis

Other

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

1 | Please see accompanying full Prescribing Information or visit [DUPIXENThcp.com](http://DUPIXENThcp.com). © 2025 Sanofi and Regeneron Pharmaceuticals, Inc. All Rights Reserved. [US.DUP.25.08.0029 08/2025]

Checking "Voicemail OK?" allows *DUPIXENT MyWay* to leave a detailed voicemail for the patient or caregiver.

Scanning the QR code allows patients to save *DUPIXENT MyWay* contact information to their mobile phone. This allows them to easily identify calls from *DUPIXENT MyWay*.

Include copies of the patient's prescription and/or medical insurance card. If not available, a patient demographic sheet may be submitted instead.

Check the appropriate box for the patient's diagnosis. If not listed, check "Other" and write in the ICD-10-CM code. Only patients diagnosed with FDA-approved indications are eligible for support.

**!** For some indications, the form may include extra fields in the diagnosis section. Be sure to fill these in if applicable.

PAGE 1

**! PAGE 2 must be completed for all patients.**

Provide the best contact name, email, and phone number for the office in case additional information is needed.

Indicate device type. To avoid delays, ensure the device type is consistent across patient documentation, including prior authorization forms and clinical records. *Pre-filled pens are for patients 2 years and older.*

Each box contains 2 pens or syringes. **300 mg: 1 box = 2 pens or syringes (600 mg total)**  
**200 mg: 1 box = 2 pens or syringes (400 mg total)**

Refer to the table for dosing guidance by age and weight, when appropriate. Dosing options will indicate the total dose and frequency.

**! Prescription must be signed and dated by the prescriber. In certain states, a collaborating MD may be required.**

If a loading dose is not required, do not check the "loading dose" box.

Indication name here

**DUPIXENT MyWay Enrollment Form**

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)

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.

**5 PRESCRIBER INFORMATION**

Patient name: \_\_\_\_\_ DOB (MM/DD/YYYY): \_\_\_\_\_

Prescriber name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Prescriber NPI #: \_\_\_\_\_ Site/facility name: \_\_\_\_\_

Office contact name: \_\_\_\_\_ Office contact email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Tax ID: \_\_\_\_\_

**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  Pre-filled pen for use in indicated patients ≥2 years

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 \_\_\_\_\_

Substitutions permitted: SIGN \_\_\_\_\_ DATE \_\_\_\_\_

Collaborating MD name: \_\_\_\_\_ NPI #: \_\_\_\_\_

**DOSING**

AGE	WEIGHT	DOSING
Age ≥X years		<input type="checkbox"/> Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 <input type="checkbox"/> Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15
X kg - <X kg	X kg - <X kg	<input type="checkbox"/> Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 <input type="checkbox"/> Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks, start on Day 29
	X-X years	<input type="checkbox"/> Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 <input type="checkbox"/> Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15
≥X kg	X kg - <X kg	<input type="checkbox"/> Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 <input type="checkbox"/> Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15
	X-X years	<input type="checkbox"/> Initial and subsequent doses: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks <input type="checkbox"/> Initial and subsequent doses: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks

**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.

2 | Please see accompanying full Prescribing Information or visit DUPIXENThcp.com. © 2025 Sanofi and Regeneron Pharmaceuticals, Inc. All Rights Reserved. [US.DUP.25.08.0029 08/2025]

**The Quick Start Program** may temporarily provide DUPIXENT at no cost to eligible commercially-insured patients experiencing a coverage delay.\*

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.

**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.

Indication name here

Patient name: \_\_\_\_\_ DOB (MM/DD/YYYY): \_\_\_\_\_

Prescriber name: \_\_\_\_\_ Prescriber NPI #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**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  Pre-filled pen for use in indicated patients ≥2 years

Refills: \_\_\_\_\_ Weight (kg): \_\_\_\_\_ 1 kg = 2.2 lbs

Known drug allergies: \_\_\_\_\_

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

Prescriber signatures (NO stamps)

Dispense as written: SIGN \_\_\_\_\_ DATE \_\_\_\_\_

Substitutions permitted: SIGN \_\_\_\_\_ DATE \_\_\_\_\_

Collaborating MD name: \_\_\_\_\_ NPI #: \_\_\_\_\_

**DOSING**

AGE	WEIGHT	DOSING
Age ≥X years		<input type="checkbox"/> Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 <input type="checkbox"/> Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15
X kg - <X kg	X kg - <X kg	<input type="checkbox"/> Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 <input type="checkbox"/> Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks, start on Day 29
	X-X years	<input type="checkbox"/> Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 <input type="checkbox"/> Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15
≥X kg	X kg - <X kg	<input type="checkbox"/> Loading dose: 000 mg SIG: 0 (000 mg/0 mL) subQ on Day 1 <input type="checkbox"/> Subsequent dose: 000 mg SIG: 0 (000 mg/0 mL) subQ every 2 weeks, start on Day 15
	X-X years	<input type="checkbox"/> Initial and subsequent doses: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks <input type="checkbox"/> Initial and subsequent doses: 000 mg SIG: 0 (000 mg/0 mL) subQ every 4 weeks

**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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**PAGE 5 - QUICK START PROGRAM**

**! PAGE 5 is optional and should only be completed when applicable. Even when blank, this page should still be included in the enrollment form submission.**

\*Eligibility requirements apply.