EYLEA4U® ENROLLMENT FORM

EYLEA® (aflibercept) Injection 4U℠

Phone: 1-855-EYLEA4U (1-855-395-3248), Option 4 Fax: 1-888-335-3264 www.EYLEA.com

Section 1.1 Support Requested (check all that apply)

☐ Benefits Investigation ☐ Appeals Support ☐ Co-Pay Assistance
☐ Prior Authorization Assistance ☐ Claims Assistance

Patient Assistance Program
☐ Patient Assistance Program (PAP)

Section 2.1 Patient Information

Gender: ☐ Male ☐ Female

First Name:_____ Middle Initial:____ Last Name:_____ SSN:_____
Date of Birth:_____ Home Phone:_____ Cell Phone:_____ E-Mail:_____
Address:_____ City:_____ State:_____ ZIP:_____

Section 2.2 Patient Insurance Information

Patient is uninsured (no third-party or private insurance) ☐ Yes ☐ No

Primary Insurance
Name:_____ Phone:_____
Insured Name:_____ Policy Number:_____
Employer:_____ Group Number:_____

Secondary Insurance
Name:_____ Phone:_____
Insured Name:_____ Policy Number:_____
Employer:_____ Group Number:_____

Section 2.3 Diagnosis/Treatment (highest level of specificity)

Eye(s) affected: ☐ Right Eye ☐ Left Eye

☐ 362.52 Exudative Senile Macular Degeneration
☐ 362.83 Retinal Edema
☐ 362.35 Central Retinal Vein Occlusion
☐ Other *(only available for PAP)*
Visual Acuity in Eye:_____ / _____

Eye(s) affected: ☐ Right Eye ☐ Left Eye

☐ 362.52 Exudative Senile Macular Degeneration
☐ 362.83 Retinal Edema
☐ 362.35 Central Retinal Vein Occlusion
☐ Other *(only available for PAP)*
Visual Acuity in Eye:_____ / _____

Has patient started treatment? ☐ Yes ☐ No Anticipated date of treatment:_____

Section 3.1 Prescription

EYLEA® (aflibercept) Injection ☐ Drug Allergies:_____ ☐ NKDA

Dispense:_____ Vial(s)_____ **Refill:**_____ times Specialty pharmacy needed for dispensing? ☐ Yes ☐ No (MD office to supply)
(each vial is intended to deliver 0.05 mL of 40 mg/mL EYLEA) Preferred specialty pharmacy:_____

SIG:☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first three months followed by 2.0 mg (0.05 mL) once every 8 weeks
SIG:☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly)
SIG:☐_____
Ship to address (if different from office shown below):_____

Section 4.1 Prescribing Physician Information

Site of Service: ☐ Physician Office ☐ Hospital Outpatient ☐ Ambulatory Surgical Center Practice/Facility Name:_____
Physician Name:_____ E-Mail:_____ Phone:_____ Fax:_____
Physician Specialty:_____ Address:_____ City:_____ State:_____ ZIP:_____
Physician's St Lic#:_____ Physician's DEA#:_____ Physician's PTAN:_____
Physician's Tax ID#:_____ Physician's National Provider Identifier (NPI):_____

Section 4.2 Office Contact Information

Primary Office Contact:_____ Phone:_____ Fax:_____ E-Mail:_____

Section 4.3 Physician Certification

My signature below certifies that the person named on this form is my patient, the information provided on this application is complete and accurate, and that EYLEA received in response to this application is only for the use of EYLEA for the patient named on this form. With regard to any patient eligible for patient assistance through the EYLEA4U® program, I acknowledge that this medication will not be offered for sale, trade, or barter and **EITHER** no claim for reimbursement of either EYLEA or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer **OR** I will provide appropriate denial and appeals documentation to support requests for patients who are deemed uninsured after a claim was submitted. I consent to Regeneron Pharmaceuticals, Inc. and its representatives and contractors contacting me by fax, phone, mail, or email to confirm receipt of EYLEA or provide additional information about EYLEA or the EYLEA4U program and that Regeneron Pharmaceuticals, Inc. may revise, change, or terminate any program services at any time without notice to me. I authorize Regeneron Pharmaceuticals, Inc. and its representatives and contractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient, and I appoint the EYLEA4U program solely to convey the prescription herein on my behalf to the pharmacy chosen by or for the above-named patient.

Physician Signature:_____ **Date:**_____

Please complete this application and submit by fax to 1-888-335-3264 or retain completed and patient-signed form on file at your office if submission is entered via the e-Portal.

Patient Name

First Name:_____ Middle Initial:_____ Last Name:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Section 5.1 **Authorization to Disclose/Use Health Information**

I authorize my health care providers, my health insurer, health plan or programs that provide me health care benefits (together, "Health Insurers") and any specialty pharmacies to disclose to Regeneron Pharmaceuticals, Inc. and its representatives and contractors (together, "Regeneron") the information on this Enrollment Application and any other information related to my treatment with EYLEA® (aflibercept) Injection (together, "My Information").

My health care providers, Health Insurers, specialty pharmacy and Regeneron may use and disclose My Information for the following purposes:

- to determine if I am eligible to participate in Regeneron's reimbursement assistance program, patient assistance program and other support programs (together, "EYLEA4U® Programs");
- for the operation and administration of the EYLEA4U Programs;
- to investigate my health insurance coverage benefits;
- to obtain prior authorization for reimbursement;
- to assist with appeals of denied claims for reimbursement; and
- to refer me to, or to determine my eligibility for, other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my medications.

I understand that, once My Information has been disclosed to Regeneron, federal privacy laws may no longer protect it. However, Regeneron agrees to protect My Information by using and disclosing it only for the purposes authorized in this Authorization or as required by law.

I understand that if I refuse to sign this Authorization, I will not be able to participate in the EYLEA4U Programs, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage.

Further, I understand that I may withdraw (take back) this Authorization at any time by mailing or faxing a written request to Regeneron at P.O. Box 220578, Charlotte, NC 28222-0578; Fax: (888) 335-3264. Withdrawal of this Authorization will end further uses and disclosures of My Information by the parties identified in this Authorization except to the extent those uses and disclosures have been made in reliance upon this Authorization.

This Authorization expires 18 months from the date support is last provided under any EYLEA4U Program unless I withdraw it earlier. For residents of California, this authorization expires 18 months from the date indicated below unless I withdraw it earlier. I understand that I will receive a copy of this Authorization.

Patient Signature:_____ **Date:**_____

Please complete this application and submit by fax to 1-888-335-3264 or retain completed and patient-signed form on file at your office if submission is entered via the e-Portal.

Patient Name

First Name:_____ Middle Initial:_____ Last Name:_____
Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Section 5.2 Financial Information (must be completed for co-pay assistance and patient assistance requests)

Total Household Income (including salary/wages; Social Security income; disability income; any other income):*
☐ $0 to $25,000 ☐ $25,001 to $50,000 ☐ $50,001 to $75,000 ☐ $75,001 to $100,000 ☐ Greater than $100,000

*Supporting documentation will be required.

Section 5.3 Patient Certification

By signing below I verify that the information on this application and other supporting documentation is complete and accurate. I also verify that unless I have identified otherwise in this application, I have no other coverage for prescription medications, including Medicaid, Medicare or any public or private assistance programs, or any other form of insurance.

I also agree that Regeneron may verify my eligibility for the EYLEA4U® Programs, and I understand that such verification may include contacting me or my health care provider for additional information and/or reviewing additional financial, insurance, and/or medical information.

In connection with administering the EYLEA4U Programs, I understand that Regeneron may contact me or my health care provider directly to confirm receipt of medications or to provide other information related to the EYLEA4U Programs. I also understand that Regeneron may revise, change or terminate the EYLEA4U Programs at any time.

Patient Signature:_____ **Date:**_____

Section 5.4 Physician Patient Signature Certification (must be signed by physician when Enrollment Form submissions are entered via the e-Portal)

My signature below certifies the following: (i) that the person named on this Enrollment Form is my patient, (ii) that I have obtained his/her written authorization and certification under Sections 5.1 and 5.3 of this form, (iii) that I have confirmed that the information, if applicable, under Section 5.2 of this form is accurate and complete, (iv) that I will retain in my files the complete patient-executed Enrollment Form, and (v) that upon request, I will promptly provide a copy of this patient-executed Enrollment Form on file to EYLEA4U.

Physician Signature:_____ **Date:**_____

Please complete this application and submit by fax to 1-888-335-3264 or retain completed and patient-signed form on file at your office if submission is entered via the e-Portal.

REGENERON 777 Old Saw Mill River Road, Tarrytown, NY 10591-6707