MyPraluent™ Enrollment Form

SKYEMED PHARMACY & INFUSION SERVICES

Pharmacy Phone: 866-778-8255
Pharmacy Fax: 800-432-6614
intake@skyemed.com

SECTION 1 - Coverage Support (Select only 1 option)

Select your preferred specialty pharmacy*

- ☐ Accredo Health Group, Inc.
- ☐ Aetna Specialty Pharmacy, LLC
- ☐ Amber Pharmacy
- ☐ Avella
- ☐ Axium Healthcare Pharmacy
- ☐ BriovaRx, LLC
- ☐ Cigna Specialty Pharmacy
- ☐ CVS Caremark Specialty Pharmacy
- ☐ Diplomat Pharmacy
- ☐ Humana Specialty Pharmacy
- ☐ Prime Therapeutics Specialty Pharmacy, LLC
- ☐ Senderra Rx
- ☐ TLCRx
- ☐ Walgreens Specialty Pharmacy Inc.
- ☑ Other: SKYEMED PHARMACY

☐ **MyPRALUENT** – Select to request full program support (e.g, benefits investigations, support for prior authorizations and appeals, copay assistance)

SECTION 2 - Patient Information

Patient Name _____ DOB _____ Sex ☐ M ☐ F
Street Address _____
City _____ State _____ ZIP _____-_____
Contact/Caregiver _____
Preferred Patient Language _____

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

Sign _____ Date MM/DD/YYYY
Patient Signature/Legal Representative*

_____
Relationship to Patient*

Preferred Phone _____ Alternate Phone _____
Best time to contact ☐ Morning ☐ Afternoon ☐ Evening
Voice mail message ☐ Preferred Phone ☐ Alternate Phone ☐ No Message
Text message ☐ Preferred Phone ☐ Alternate Phone ☐ No Message
Email _____
Preferred Contact ☐ Phone ☐ Text Message ☐ Email

I have read and agree to the Patient Authorization to Use and Disclose Health Information included in section 9.

Sign _____ Date MM/DD/YYYY
Patient Signature/Legal Representative*

_____
Relationship to Patient*

*If signed by someone other than the patient, please describe your authority to sign on behalf of the patient.

☐ By checking this box, I indicate that I have read the Text Messaging Consent in section 8 and expressly consent to receive text messages by or on behalf of the Program.

SECTION 3 - Insurance Information (please attach copies of front and back of medical and prescription cards)

PRIMARY INSURER

Insurer _____ ☐ No Insurance
Insurance Phone _____
Policy ID Number _____
Group Number _____

PRESCRIPTION DRUG INSURER

Insurer _____ ☐ No Insurance
Insurance Phone _____
Policy ID Number _____ Group Number _____
Rx BIN Number _____ Rx PCN Number _____

SECTION 4 - Prescriber And Rx Information

Prescriber Name _____
Site/Facility Name _____
Address _____
City _____ State _____ ZIP _____-_____
Phone _____ Fax _____
Office Contact Name _____
Office Contact Email _____
Prescriber NPI # _____ State License # _____
Prescriber Specialty Area _____

Rx Information: PRALUENT® (alirocumab) injection

- ☐ 75 mg/mL Pre-Filled **Pen** 2-Pack
  SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____
- ☐ 150 mg/mL Pre-Filled **Pen** 2-Pack
  SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____
- ☐ 75 mg/mL Pre-Filled **Syringe** 2-Pack
  SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____
- ☐ 150 mg/mL Pre-Filled **Syringe** 2-Pack
  SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____

Sharps container to be provided.

Drug Allergies _____ ☐ NKDA

NY State Prescribers: Please submit prescription on an original NY State prescription blank.

Sign _____ Date **MM/DD/YYYY**
Prescriber Signature (no stamps) (Dispense as Written)

Sign _____ Date **MM/DD/YYYY**
Prescriber Signature (no stamps) (Substitution Permitted)

☐ Check this box to initiate a benefits investigation without a patient signature in section 2. By checking this box, I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to reimbursement support programs such as MyPRALUENT and the Alliance for purposes of conducting an investigation of my patient's health insurance coverage benefits for PRALUENT.

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, and that therapy with PRALUENT is medically necessary. I understand that my patients' information provided to Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (the "Alliance"), is for the use of MyPRALUENT solely to verify my patient's insurance coverage, to assess, if applicable, my patient's eligibility for patient assistance and other support programs, and to otherwise administer MyPRALUENT for the patient. I request MyPRALUENT to conduct a benefit investigation for my patient and authorize MyPRALUENT to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan; provided that if this prescription is not so designated, MyPRALUENT is authorized to transmit this prescription to a network pharmacy it selects, or to the pharmacy otherwise indicated. I consent to MyPRALUENT contacting me by fax, mail, or email to provide additional information about PRALUENT or MyPRALUENT, and that MyPRALUENT may revise, change, or terminate any program services at any time without notice to me.

*While you may select any specialty pharmacy for assistance, please note that individual specialty pharmacies may require their own intake forms in addition to the **MyPRALUENT** Enrollment Form.

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SECTION 5 - Treatment Information

☐ New Start
☐ Reauthorization
☐ Continuation (new insurance)

ICD-10 Diagnosis Codes

Select at least one primary and one secondary ICD-10 code.
Include as many appropriate clinical ASCVD codes as necessary to support your patient's diagnosis.

Primary diagnosis (MUST select at least one).

☐ E78.0 (Pure Hypercholesterolemia, including HeFH)
☐ E78.2 (Mixed Hyperlipidemia)
☐ E78.4 (Other Hyperlipidemia)
☐ E78.5 (Unspecified Hyperlipidemia)

If E78.2, E78.4, or E78.5 is selected, select a secondary diagnosis code as applicable.

Please refer to the coding reference list provided with this form for specific ASCVD codes.

Arteriosclerotic Heart Disease	☐ I25.__	History of Ischemic Stroke	☐ I69.__
Acute Coronary Syndromes	☐ I23.__ ☐ I24.__	With Residuals	
Acute Myocardial Infarction (active)	☐ I21.__ ☐ I22.__	Atherosclerosis of Peripheral and	☐ I70.__
Coronary Revascularization	☐ Z95.__ ☐ Z98.__	Other Non-coronary, Non-cerebral Vessels	
Arteriosclerotic Cerebrovascular Disease Ischemic Stroke	☐ I65.__ ☐ I66.__ ☐ I67.__ ☐ I63.__	Peripheral Artery Revascularization	☐ Z95.__ ☐ Z98.__
Transient Ischemic Attack	☐ G45.__	Other	☐ ___.__ ☐ ___.__ ☐ ___.__

LDL-C Values:

Current LDL-C _____ mg/dL Date: mm/yy _____

Previous And/Or Current Lipid-Lowering Treatments (dose mg/day)

☐ None ☐ Yes (please indicate below)

	Dose	Start date	Stop date	Intolerant	Current
☐ atorvastatin				☐	☐
☐ pravastatin				☐	☐
☐ rosuvastatin				☐	☐
☐ simvastatin				☐	☐
☐ ezetimibe				☐	☐
☐ Other				☐	☐

Last date on lipid-lowering treatment: mm/dd/yyyy _____

Failure on or contraindications to any of the above therapies?

_____

_____

_____

☐ Consultation with specialist (e.g., cardiologist, lipidologist)

_____

History of ASCVD event

☐ None ☐ Yes (please indicate below)

Date: mm/yy _____

☐ Angina
☐ Myocardial Infarction
☐ Transient Ischemic Attack
☐ Percutaneous Transluminal Coronary Angioplasty
☐ Peripheral Artery Disease
☐ Stroke
☐ Coronary or Other Arterial Revascularization

Primary Care Provider Information

Primary Care Provider Name _____

Primary Care Provider Phone _____

SECTION 6 - Patient Education

☐ Clinical nursing support including product administration training

SECTION 7 - Household Income

(required if requesting MyPRALUENT™ Patient Assistance for uninsured patients or for patients who lack pharmacy benefit coverage)

Total Annual Household Income*

☐ $0 to $100,000

☐ Greater than $100,000

*Salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.

To qualify for the MyPRALUENT Patient Assistance Program, I understand that I must not have confirmed insurance coverage for PRALUENT, and I must meet certain income and other eligibility requirements. MyPRALUENT may ask for proof of income at any time for the purpose of audit/verification. If requested, I agree to provide proof of income within thirty (30) days of the request.

Continuation in the program is conditioned upon timely verification of income. In addition, I agree to notify MyPRALUENT if my insurance situation changes.

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SECTION 8 - Patient Certifications (Please read the following carefully, then date and sign where indicated in section 2 of page 1)

I am enrolling in the MyPRALUENT™ Program (the "Program") and authorize Regeneron Pharmaceuticals, Inc., Sanofi US, and their 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").

I agree to my enrollment in the MyPRALUENT Copay Card program if confirmed as eligible, understand that Copay Card information will be sent to my designated specialty pharmacy/in-network specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or co-payment for PRALUENT® (alirocumab) will be made in accordance with the Program terms and conditions.

If I am completing Section 7, I confirm my agreement with the conditions set forth in Section 7, and certify that the number of people in my household and my household income are true and accurate to the best of my knowledge.

I authorize the Alliance to contact me by mail, telephone, or email, or, if I indicate my agreement and consent below, by text*, with information about the Program, hypercholesterolemia and products, promotions, services and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize the Alliance to de-identify my health information and use it in performing research, education, business analytics, marketing studies or for other commercial purposes. I understand that members of the Alliance may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services or to send the communications listed above (the "Communications"). I understand and agree that the Alliance may use my health information for these purposes and may share my health information with my doctors, specialty pharmacies, and insurers.

I understand that I do not have to enroll in the Program or receive the Communications, and that I can still receive PRALUENT, as prescribed by my physician. I may opt out of receiving Communications, individual support services offered by the Program, including the MyPRALUENT Copay Card, or opt out of the Program entirely at any time by notifying a Program representative by telephone at **1-844-PRALUENT** or by sending a letter to MyPRALUENT, 1670 Century Center Parkway, Memphis, TN 38134. I also understand that the Services may be revised, changed, or terminated at any time.

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 from future text messages at any time by texting STOP to 32982 from my mobile phone, and that I can get help for text messages by texting HELP to 32982. 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. I understand that my consent is not required as a condition of purchasing any goods or services from Regeneron Pharmaceuticals, Inc. or Sanofi. Message and data rates may apply.

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

Fax all 4 pages to Skyemed Pharmacy at 800-432-6614

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SECTION 9 - Patient Authorization To Use And Disclose Health Information (Please read the following carefully, then date and sign where indicated in section 2 of page 1)

I authorize my healthcare providers and staff, my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies that dispense my medication to disclose to Regeneron Pharmaceuticals, Inc., Sanofi US, and their agents (together, the "Alliance") health information about me, including information related to my medical condition and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the Program ("My Information") for the purposes of enrolling me in and providing certain services, including

- to determine if I am eligible to participate in MyPRALUENT™ coverage assistance programs, patient assistance programs or other support programs
- to investigate my health insurance coverage for PRALUENT® (alirocumab) injection
- to obtain prior authorization for coverage
- to assist with appeals of denied claims for coverage
- for the operation and administration of the 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 and agree that my healthcare providers, Health Insurers, and specialty pharmacy(ies) 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 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, the Alliance agrees to protect My Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise allowed 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, insurance coverage, access to health benefits or Alliance medications. However, if I do not sign this Authorization, I understand that I will not be able to participate in the MyPRALUENT coverage assistance programs.

I understand that this Authorization shall remain in effect until my participation in the MyPRALUENT Program ends unless and until I withdraw (take back) this Authorization before then. Further, I understand that I may withdraw this Authorization at any time by mailing or faxing a written request to MyPRALUENT at 1670 Century Center Parkway, Memphis, TN 38134; Fax: 1-844-872-5447. Withdrawal of this Authorization will end my Participation in the MyPRALUENT coverage assistance programs 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 and staff, my Health Insurers and specialty pharmacies.

Fax all 4 pages to Skyemed Pharmacy at 800-432-6614