DUPIXENT myway

DUPIXENT MyWay™ Copay Card Program Reimbursement Form

If you have paid your copay in full in the last 90 days, you may be eligible for reimbursement of certain product-specific copay, co-insurance or deductible costs directly and actually incurred for a prescription for **DUPIXENT®** under the ***DUPIXENT MyWay*** Copay Card Program.

Reimbursement is subject to program terms and conditions. Payment of the reimbursement is also subject to verification. Submission of this form is not a guarantee of payment.

PATIENT INFORMATION – please print

First Name _____ Middle _____ Last Name_____
Address 1 _____ Address 2 _____
City _____ State _____ Zip _____
Phone _____ Email _____
Date of Birth _____ Gender _____ Age _____

PRESCRIBER INFORMATION – please print

First Name _____ Middle _____ Last Name_____
Address 1 _____ Address 2 _____
City _____ State _____ Zip _____
Phone _____
Prescription / Mail Order Provider _____

REIMBURSEMENT PROCESS

Please fill out all fields on this form completely and attach the items listed below. Forms submitted without these items will not be eligible for reimbursement. Forms will generally take 7 to 10 business days to process:

- ☐ Copy of **DUPIXENT** prescription label (prescription receipt from the pharmacy that includes name and address of pharmacy, dosing, and days supply)
- ☐ Copy of the front and back of ***DUPIXENT MyWay*** Copay Card
- ☐ Dated original cash register receipt (proof of purchase or invoice) with the amount of copay or out-of-pocket expenses highlighted
- ☐ Patient signature and certification (see below)

Submit reimbursement request and attachments via mail or fax.
Mail: ***DUPIXENT MyWay*** Copay Reimbursement Program, PO Box 7017, Bedminster, NJ 07921-7017
Fax: **1-908-809-6249**

I, (Insert Name) _____, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the product-specific copay, co-insurance, or deductible expenses requested for reimbursement were actually incurred. My prescription for **DUPIXENT** was not paid in whole or in part by Medicare, Medicaid, or any federal or state programs.

Patient Signature _____

If you have questions about the ***DUPIXENT MyWay*** Copay Card or you wish to discontinue your participation, please contact us at **1-855-314-8944**, 24 hours a day, 7 days a week.

SANOFI GENZYME REGENERON

DUPIXENT® (dupilumab)