DUPIXENT myway®

Enrollment Form

Fax: 1-844-387-9370 | **Phone: 1-844-DUPIXEN(T) (1-844-387-4936) Option 1**
To prevent delays, complete the entire form and fax it to the number above.
For assistance, call us at the number above, Monday–Friday, 8 AM–9 PM Eastern time.

DUPIXENT® (dupilumab) Injection
200mg · 300mg

Patient to Fill Out

Section 1. Patient Information

Patient name (first, MI, last) _____
Address _____
City _____ State _____ ZIP _____
DOB (mm/dd/yyyy)_____ Gender ☐F ☐M
Preferred patient language (if not English) _____

Alternate phone (____)_____ ☐Preferred # ☐Voicemail
Mobile phone (____) _____ ☐Preferred # ☐Voicemail
☐I have read the Text Messaging Consent in Section 9 and expressly consent to receive text messages by or on behalf of the Program
Email _____

Patient Authorization

I have read and agree to the Patient Authorization to Use and Disclose Health Information included in Section 8

Sign _____
Patient signature/Legal representative Date (mm/dd/yyyy)
If signed by a legal representative:
Print name Relationship to patient

I have read and agree to the Patient Certifications included in Section 9

Sign _____
Patient signature/Legal representative Date (mm/dd/yyyy)
If signed by a legal representative:
Print name Relationship to patient

Section 2. Insurance Information

☐ No insurance *(Please fill out Section 7 if you do not have health insurance.)*

Please attach copies of front and back of primary medical and prescription cards.

Primary medical insurance name _____
Insurance phone (_____) _____
Policy ID # _____
Group # _____
Policy holder name (first/last) _____
Relationship to patient _____

Primary Rx insurance name (if different) _____
☐Secondary insurance card attached
Rx insurance phone (_____) _____
Policy ID # _____
Group # _____
Rx BIN #_____ Rx PCN # _____

Prescriber to Fill Out

Section 3. Prescriber Information

Prescriber name _____
Prescriber NPI # _____ Group tax ID #_____
Specialty _____
Address _____
City _____ State _____ ZIP_____

Site/facility name _____
Office contact name_____
Office contact email _____
Phone (_____) _____
Fax (_____) _____

Section 4. Diagnosis (Complete **ONE** diagnosis only)

Clinical and Prescription Information (*Please attach any office chart notes relevant to therapy.*)

Moderate-to-severe atopic dermatitis

ICD-10-CM code(s) L20._____ **L20.**_____ Date of diagnosis_____
See the list of potential ICD-10-CM codes on last page
☐Primary ☐Secondary
☐Patient has moderate-to-severe AD that is inadequately controlled on prior or current topical therapy[a]
For patients 12-17, weight in kg: _____ kg (1 kg = 2.2 lb)
Severity: BSA involved ☐under 10% ☐10% or more
Scoring tool name_____ Score_____
Sensitive areas affected (*Check all that apply.*) ☐hands ☐feet ☐face and neck ☐genitals/groin ☐scalp ☐intertriginous areas ☐other_____
☐Atopic comorbidities (specify)_____

[a]Moderate-to-severe AD is defined as moderate-to-severe erythema and moderate-to-severe papulation/infiltration.[1]
1. Futamura M et al. *J Am Acad Dermatol*. 2016;74(2):288-294.

Moderate-to-severe asthma with eosinophilic phenotype or oral corticosteroid dependent asthma

ICD-10-CM code(s) J45._____ **J45.**_____ Date of diagnosis_____
See the list of potential ICD-10-CM codes on last page
☐Primary ☐Secondary
☐Patient has moderate-to-severe asthma that requires add-on maintenance treatment
☐Patient has moderate-to-severe asthma with an eosinophilic phenotype
Eosinophil levels (if available)_____ cells/mcL Test date_____
☐Patient has moderate-to-severe asthma with oral corticosteroid-dependent asthma
Pre-bronchodilator FEV_1 <80% (adults) or <90% (aged 12–17 years) ☐Yes ☐No
☐Atopic comorbidities (specify) _____
Number of severe exacerbations in the past 12 months_____

Please see full indications on next page.
AD=atopic dermatitis; BSA=body surface area; FEV_1=forced expiratory volume in 1 second; ICD-10-CM=*International Classification of Diseases, Tenth Revision, Clinical Modification.*

Section 5. Prescription Information

My preferred specialty pharmacy is _____
Phone (_____) _____ Fax (_____) _____
Sample product: ☐No sample provided ☐Sample provided on _____

☐**I have already sent this prescription to the specialty pharmacy. By checking the box, I acknowledge *DUPIXENT MyWay*® will not conduct a benefits verification. The specialty pharmacy is responsible for securing coverage on my patient's behalf.**

Rx: DUPIXENT® (dupilumab), prefilled syringe, 2 pack

☐Initial dose:	400 mg	SIG: 2 injections subcutaneously on Day 1
☐Maintenance dose:	200 mg	SIG: 1 injection every 2 weeks starting on Day 15
	Qty: 2 pk	Refills _____
☐Initial dose:	600 mg	SIG: 2 injections subcutaneously on Day 1
☐Maintenance dose:	300 mg	SIG: 1 injection every 2 weeks starting on Day 15
	Qty: 2 pk	Refills _____

☐Maintenance: Other
Dose _____ SIG: _____
Frequency _____ Qty _____ Refills_____
Known drug allergies: _____

Sign _____
Prescriber signature (No stamps) ☐ Dispense as written Date (mm/dd/yyyy)

Collaborating MD name_____ **NPI #**_____
(Nurse practitioner/physician assistant)

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 DUPIXENT is medically necessary. 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 assess, if applicable, my patient's eligibility for patient assistance and other support programs; and to otherwise administer *DUPIXENT MyWay* for the patient. I request *DUPIXENT MyWay* to conduct a benefits investigation for my patient and authorize *DUPIXENT MyWay* 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 free product 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*, and 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.

Please click here for full Prescribing Information.

*Complete entire form and fax **the first 4 PAGES** to DUPIXENT MyWay at **1-844-387-9370.***

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DUPIXENT® (dupilumab) Injection
200mg · 300mg

Patient Name

Prescriber Name NPI#

INDICATIONS

Atopic Dermatitis: DUPIXENT is indicated for the treatment of patients aged 12 years and older with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids.

Asthma: DUPIXENT is indicated as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma.

Limitation of Use: DUPIXENT is not indicated for the relief of acute bronchospasm or status asthmaticus.

Prescriber to Fill Out

Section 6. Current and Prior Therapies

Moderate-to-severe atopic dermatitis

Topical therapies	Duration
	____ to ____
	____ to ____

☐ Topical therapies are inappropriate for this patient
Rationale _____

Systemic corticosteroids, immunosuppressants, and/or phototherapy	Duration
	____ to ____
	____ to ____
	____ to ____

☐ Systemic corticosteroids are inappropriate for this patient
☐ Immunosuppressants are inappropriate for this patient
☐ Phototherapy is inappropriate for this patient
Rationale _____

Moderate-to-severe asthma with eosinophilic phenotype or oral corticosteroid dependent asthma

ICS without LABA	Duration
	____ to ____
	____ to ____

☐ Inhaled corticosteroids (without LABA) are inappropriate for this patient
Rationale _____

Oral and/or injectable corticosteroids	Duration
	____ to ____
	____ to ____

☐ Oral and/or injectable corticosteroids are inappropriate for this patient
Rationale _____

Combination therapy (ICS/LABA)	Duration
	____ to ____
	____ to ____

☐ Combination therapy (ICS/LABA) is inappropriate for this patient
Rationale _____

Other controllers (specify)	Duration
	____ to ____
	____ to ____

☐ Other controllers are inappropriate for this patient
Rationale _____

ICS=inhaled corticosteroid; LABA=long-acting beta agonist.

Patient to Fill Out

Section 7. Household Income

Required if enrolling in the *DUPIXENT MyWay*® Patient Assistance Program

How many people live in your household? _____

What is your total annual household income? _____
(Includes salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.)

I agree that Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together, the "Alliance") may 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 Social Security number and/or additional 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. 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.

Patient Name

Prescriber Name NPI#

Section 8. Authorization to Use and Disclose Health Information

Please read the following carefully, then date and sign where indicated in Section 1 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 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 understand the disclosure to the Alliance will be 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 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 authorize and agree that the Alliance's field level employees may have access to My Information in order to assist the Alliance in providing support services in connection with the *DUPIXENT MyWay* Program. 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 *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 will 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 *DUPIXENT MyWay* Program.

I understand that this Authorization expires 18 months from the date support is last provided under the Program, 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. Further, I understand that I may withdraw this Authorization at any time by mailing or faxing a written request to *DUPIXENT MyWay* at 1800 Innovation Point, Fort Mill, SC 29715; 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 and staff, my Health Insurers, and specialty pharmacy(ies).

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

Patient Name

Prescriber Name NPI#

Section 9. Patient Certifications

Please read the following carefully, then date and sign where indicated in Section 1 of page 1

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").

I agree to my enrollment in the *DUPIXENT MyWay* Copay Card Program if confirmed as eligible, 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.

If I am completing Section 7, I confirm my agreement with the conditions set forth in Section 7, and certify that my household income is true and accurate to the best of my knowledge. I authorize the Alliance to contact me by mail, telephone, or e-mail, or, if I indicate my agreement and consent on page 1, by text,[a] with information about the Program, disease state 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, including linkage with other de-identified information the Alliance receives from other sources, 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 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 physician. 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 or by sending a letter to *DUPIXENT MyWay*, 1800 Innovation Point, Fort Mill, SC 29715. I also understand that the Services may be revised, changed, or terminated at any time.

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.

Text Messaging Consent:

[a]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 SMSSTOP to 39771 from my mobile phone, and that I can get help for text messages by texting SMSHELP to 39771. 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 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.

DUPIXENT myway®

List of potential ICD-10-CM codes

Moderate-to-severe atopic dermatitis

- **L20** (Atopic dermatitis)
- **L20.0** (Besnier's prurigo)
- **L20.81** (Atopic neurodermatitis)
- **L20.82** (Flexural eczema)
- **L20.84** (Intrinsic [allergic] eczema)
- **L20.89** (Other atopic dermatitis)
- **L20.9** (Atopic dermatitis, unspecified)

Moderate-to-severe asthma with eosinophilic phenotype or oral corticosteroid dependent asthma

- **J45.4** (Moderate persistent asthma)
- **J45.40** (Moderate persistent asthma, uncomplicated)
- **J45.41** (Moderate persistent asthma with [acute] exacerbation)
- **J45.5** (Severe persistent asthma)
- **J45.50** (Severe persistent asthma, uncomplicated)
- **J45.51** (Severe persistent asthma with [acute] exacerbation)
- **J45.9** (Other and unspecified asthma)
- **J45.90** (Unspecified asthma)
- **J45.901** (Unspecified asthma with [acute] exacerbation)

This coding information is provided for informational purposes only and is subject to change. These codes may not apply to all patients or to all health plans; providers must exercise independent judgment when selecting codes and submit claims that accurately reflect the diagnoses of a specific patient.

SANOFI GENZYME REGENERON

Please click here for full Prescribing Information.

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200mg · 300mg