MyPraluent™ Enrollment Form

For help enrolling your patients, call us at 1-844-PRALUENT (1-844-772-5836), option 1.

Enroll Your Patient Today

With MyPRALUENT™ for PRALUENT® (alirocumab), support is available to your patient as soon as you prescribe. We offer comprehensive product and patient support throughout the treatment journey. Getting started is easy—just follow the steps below to enroll your patients.

Simple Steps To Enroll Your Patient

1. Complete the required fields and sign where indicated
2. Have your patient read and sign sections 6 and 7 of this form
3. Fax all completed forms to **1-844-872-5447**

After the forms have been submitted, a fax will be sent to your office to confirm the enrollment. Your patient will also receive a welcome call from a member of our team.

Comprehensive Support

MyPRALUENT has many support programs available to meet your patients' needs. Simply fill out the required sections for the support requested. Patients must read and sign sections 6 and 7 to enroll.

- MyPRALUENT enrollment and benefits investigation
  - Complete sections 1, 2, and 3. Have your patient read and sign sections 6 and 7
  - If commercially insured, eligible patients may receive out-of-pocket copay assistance through the **MyPRALUENT Copay Card**
  - Eligible patients will be automatically enrolled in this program with submission of a completed Enrollment Form
- **MyPRALUENT Bridge Program** (for eligible patients to temporarily receive PRALUENT, free of charge, during the appeals process after initial coverage denials*)
  - Complete section 4 in addition to sections 1, 2, and 3. Have your patient read and sign sections 6 and 7. Please note that this program is optional
- **MyPRALUENT Patient Assistance Program** (optional program for uninsured patients or those lacking coverage for PRALUENT*)
  - Complete sections 1, 2, and 3. Have your patient complete section 5, and have your patient read and sign sections 6 and 7
- Injection training and support (e.g., PRALUENT administration training and support)
  - Support is available to patients enrolled in MyPRALUENT
  - For patients taking PRALUENT and not yet enrolled in MyPRALUENT, complete section 1. Have your patient read and sign sections 6 and 7

*Additional eligibility criteria apply. Please call a MyPRALUENT care specialist at 1-844-PRALUENT (1-844-772-5836), option 1, to learn more.

Fax all completed forms to 1-844-872-5447.

Please see page 2 for Important Safety Information and click here for full Prescribing Information.

INDICATION

PRALUENT® (alirocumab) is a PCSK9 (Proprotein Convertase Subtilisin/Kexin Type 9) inhibitor antibody indicated as adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease, who require additional lowering of LDL-C.

The effect of PRALUENT on cardiovascular morbidity and mortality has not been determined.

IMPORTANT SAFETY INFORMATION

PRALUENT is contraindicated in patients with a history of a serious hypersensitivity reaction to PRALUENT. Reactions have included hypersensitivity vasculitis and hypersensitivity reactions requiring hospitalization.

Hypersensitivity reactions (e.g., pruritus, rash, urticaria), including some serious events (e.g., hypersensitivity vasculitis and hypersensitivity reactions requiring hospitalization), have been reported with PRALUENT treatment. If signs or symptoms of serious allergic reactions occur, discontinue treatment with PRALUENT, treat according to the standard of care, and monitor until signs and symptoms resolve.

The most commonly occurring adverse reactions (≥5% of patients treated with PRALUENT and occurring more frequently than with placebo) are nasopharyngitis, injection site reactions, and influenza.

Local injection site reactions including erythema/redness, itching, swelling, and pain/tenderness were reported more frequently in patients treated with PRALUENT (7.2% versus 5.1% for PRALUENT and placebo, respectively). Few patients discontinued treatment because of these reactions (0.2% versus 0.4% for PRALUENT and placebo, respectively), but patients receiving PRALUENT had a greater number of injection site reactions, had more reports of associated symptoms, and had reactions of longer average duration than patients receiving placebo.

Neurocognitive events were reported in 0.8% of patients treated with PRALUENT and 0.7% of patients treated with placebo. Confusion or memory impairment were reported more frequently by those treated with PRALUENT (0.2% for each) than in those treated with placebo (<0.1% for each).

Liver-related disorders (primarily related to abnormalities in liver enzymes) were reported in 2.5% of patients treated with PRALUENT and 1.8% of patients treated with placebo, leading to treatment discontinuation in 0.4% and 0.2% of patients, respectively. Increases in serum transaminases to greater than 3 times the upper limit of normal occurred in 1.7% of patients treated with PRALUENT and 1.4% of patients treated with placebo.

The most common adverse reactions leading to treatment discontinuation in patients treated with PRALUENT were allergic reactions (0.6% versus 0.2% for PRALUENT and placebo, respectively) and elevated liver enzymes (0.3% versus <0.1%).

PRALUENT is a human monoclonal antibody. As with all therapeutic proteins, there is a potential for immunogenicity with PRALUENT.

Please see Important Safety Information and click here for full Prescribing Information.

MyPraluent™

Enrollment Form

Fax all completed forms to 1-844-872-5447.

SECTION 1 Patient Information

Patient Name ______________ Gender ☐ M ☐ F

Street Address ______________

City ______________ State ______ ZIP ______

DOB ______________

Primary Phone ______________ Other Phone ______________

Okay to leave voice mail message: ☐ Primary Phone ☐ Other Phone

Email ______________

Alternate Contact/Caregiver ______________

Primary Phone ______________ Other Phone ______________

Okay to leave voice mail message: ☐ Primary Phone ☐ Other Phone

Patient's Primary Language: ☐ English ☐ Spanish ☐ Other ______

No Insurance? ☐

Insurance Information (A copy of the front and back of the patient's insurance cards may be included with Enrollment Form)

PRIMARY INSURER

Primary Insurer ______________

Insurance Phone ______________

Policy ID Number ______________

Group Number ______________

PRESCRIPTION DRUG INSURER

Prescription Drug Insurer ______________

Insurance Phone ______________

Policy ID Number ______________ Group Number ______________

Rx BIN Number ______________ Rx PCN Number ______________

SECTION 2 Treatment And Prescribing Information

Diagnosis

ICD-9 Codes

Hypercholesterolemia (MUST select at least one)

☐ 272.0 (Pure Hypercholesterolemia, including HeFH)

☐ 272.2 (Mixed Hyperlipidemia)

☐ 272.4 (Other and Unspecified Hyperlipidemia)

For ASCVD patients, ***MUST*** select appropriate code for Hypercholesterolemia AND ASCVD.

Clinical ASCVD (check all that apply)

Ischemic Heart Disease

☐ 410 Acute myocardial infarction

☐ 412 Old myocardial infarction

☐ 413 Angina pectoris

☐ 414 Other forms of chronic ischemic heart disease

☐ 411 Other acute and subacute forms of ischemic heart disease

Cerebrovascular and Peripheral Vascular Disease

☐ 433 Occlusion and stenosis of precerebral arteries

☐ 434 Occlusion of cerebral arteries

☐ 435 Transient cerebral ischemia

☐ 438 Late effects of cerebrovascular disease

☐ 440 Atherosclerosis

Other ASCVD-specific code(s) ______________

☐ **Sharps container and alcohol pads to be provided as needed.**

Lab Value

☐ LDL-C ______ mg/dL Date: mm/yy ______

Previous Or Current Lipid-Lowering Treatments

☐ None ☐ Yes (Check all that apply)

	Strength/Frq	Dates of Therapy
☐ atorvastatin	______ mg/ ____	mm/yy ______ to ______
☐ ezetimibe	______ mg/ ____	mm/yy ______ to ______
☐ pravastatin	______ mg/ ____	mm/yy ______ to ______
☐ rosuvastatin	______ mg/ ____	mm/yy ______ to ______
☐ simvastatin	______ mg/ ____	mm/yy ______ to ______
☐ Other ______	______ mg/ ____	mm/yy ______ to ______
☐ Other ______	______ / ____	mm/yy ______ to ______

Rx Information: PRALUENT® (alirocumab) Injection

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

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

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

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

Drug Allergies: ______________ ☐ NKDA

SECTION 3 Prescriber Information

Prescriber Name ______________

Site/Facility Name ______________

Address ______________

City ______________ State ______ ZIP ______

Phone ______________ Fax ______________

Office Contact Name ______________

Office Contact Email ______________

Office Contact Phone ______________

NPI # ______________ State License # ______________

Prescriber Specialty Area ______________

Prescriber Certification

My signature below 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® (alirocumab) is medically necessary. I understand that my patients' information provided to Regeneron Pharmaceuticals, Inc., Sanofi US, and their agents, 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 about PRALUENT or MyPRALUENT, and that MyPRALUENT may revise, change, or terminate any program services at any time without notice to me.

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

Supervising Prescriber Name (if applicable) ______________

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

SECTION 4 MyPRALUENT Bridge Program For Eligible Patients* (Optional, free of charge to patient)

_ **Yes,** I authorize for my patient one or more months (up to 3 months) of shipments of PRALUENT during the appeals process after an initial coverage denial for PRALUENT by the patient's insurer. I authorize MyPRALUENT to forward this prescription to the pharmacy dispensing the MyPRALUENT Bridge Program product to the patient named herein.

*Patients with Commercial Insurance or Government Insurance are eligible to apply.

Patient Name ______________________________

SECTION 5 Household Income (Required if requesting MyPRALUENT™ Patient Assistance for patients without insurance)

Total Number of People within Household (including applicant) _______

Total Annual Household Income $ ______________ (Current annual household income includes annual gross salary/wages, Social Security income, unemployment insurance benefits, disability income, workers compensation, and 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® (alirocumab) injection, 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.

SECTION 6 Patient Certifications

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 will be made in accordance with the program terms and conditions.

If I am completing Section 5, I confirm my agreement with the conditions set forth in Section 5, 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, 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® (alirocumab), 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.

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Patient Signature/Legal Representative* ______________________ **Date** __________

Relationship to Patient* ______________________

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

MyPraluent™ Enrollment Form

Fax all completed forms to 1-844-872-5447.

Patient Name ______________________________

SECTION 7 Patient Authorization To Use And Disclose Health Information

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 Programs 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.

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

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Patient Signature/Legal Representative* ____________________ **Date** __________

Relationship to Patient* ______________________________

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

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