

Option 1: Complete and fax page 1 to KevzaraConnect® at [1-844-538-8960](tel:1-844-538-8960).
Option 2: Complete and upload page 1 to the Patient Support Portal
(www.KevzaraConnectPortal.com and enter code 8445388960).

Patient Assistance Program Application

[Click here](#) for full Prescribing Information, including **Boxed WARNING**.

PATIENT TO FILL OUT

SECTION 1 – Patient Information *Required information **Please fill out each field directly on this form.**

Patient Name (First, MI, Last)* _____ **DOB (mm/dd/yyyy)*** _____ **Sex Assigned at Birth** **M** **F**
Street Address* _____ **Phone*** _____
City* _____ **State*** _____ **ZIP Code*** _____
Email* _____

Insurance Information Patient has no insurance. (Please fill out Section 2.) *Attached copies of front and back of primary prescription and medical cards*

Primary Rx Insurance Name _____ **Primary Medical Insurance Name** _____
Rx Insurance Phone (_____) _____ **Insurance Phone (_____)** _____
Policy ID # _____ **Group #** _____ **Policy ID #** _____ **Group #** _____
Rx BIN # _____ **Rx PCN #** _____ **Policyholder Name (First/Last)** _____
Relationship to Patient _____

PATIENT AUTHORIZATION I have read and agree to the Patient Certifications included in Section 5. **PLEASE NOTE: Both the Patient and the Prescriber must sign on page 1 before submitting.** I have read and agree to the Patient Authorization to Use and Disclose Health Information included in Section 6.

Sign _____ **Date (mm/dd/yyyy)** _____ **Sign** _____ **Date (mm/dd/yyyy)** _____
Patient Signature/Legal Representative _____ **Patient Signature/Legal Representative** _____
If signed by a legal representative _____ If signed by a legal representative _____
Printed Name _____ **Relationship to Patient** _____ **Printed Name** _____ **Relationship to Patient** _____

PRESCRIBER TO FILL OUT

SECTION 2 – Prescriber Information

Prescriber Name (First, MI, Last) _____ **Practice Name** _____
Specialty _____ **Title** _____ **Street Address** _____
NPI# _____ **City** _____ **State** _____ **ZIP Code** _____
Office Contact Name _____ **Phone** _____ **Fax** _____
Office Contact Email _____

SECTION 3 – Clinical and Diagnosis Information (Please attach the patient’s current medication list, previous therapies, H&P, latest clinical note.)

Primary ICD-10 Diagnosis Code _____ **Allergies** _____ **TB/PPD Test Date** _____ **POS** **NEG**
Previous Therapies _____

SECTION 4 – Patient Assistance Program Prescription Information

KEVZARA Injection: single-dose pre-filled pen, Package of 2
200 mg/1.14 mL 150 mg/1.14 mL

Refills _____ **Days' supply** 28 84
SIG 1 injection subcutaneously every 2 weeks **Other** _____

Prescriber Attestation: By signing this form, I certify that: (a) the information provided is complete and accurate to the best of my knowledge; and (b) the prescribed therapy with KEVZARA is medically necessary for the patient. I confirm that I have obtained all necessary patient authorizations, in compliance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, to release their personal, medical, and insurance information and any prescription to Sanofi US, Regeneron Pharmaceuticals, Inc., and their affiliates, agents, and service providers (the "Alliance") for use by KevzaraConnect® to verify insurance; facilitate prescription fulfillment such as sending my prescription to the appropriate pharmacy designated by the patient per their benefit plan provided that, if this prescription is not so designated, KevzaraConnect® is authorized to transmit it to a network pharmacy it selects; assess eligibility for assistance programs; and provide patient support services. Further, I have discussed and confirmed the patient's agreement that they would like to receive the Services and Communications set forth in the Patient Certifications. I understand that prescribing KEVZARA is not required and is based solely on my clinical judgment. I consent to the Alliance contacting me via fax, mail, or email with KEVZARA or KevzaraConnect® information. I acknowledge that the Alliance may modify or discontinue program services at any time without notice. I understand that any free product provided is not tied to purchase obligations. No claims will be submitted to Medicare, Medicaid, or other payers for free medication, and such product will not be sold, traded, or redistributed. I authorize the Alliance to transmit this prescription to the appropriate pharmacy and agree to support efforts to secure access to KEVZARA for my patient in case of coverage delays.

The prescriber is to comply with 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.

Sign _____ **Collaborating MD Name** _____ **NPI#** _____
Prescriber Signature (No Stamps) (Dispense as Written) _____ **Date (mm/dd/yyyy)** _____ **(For Mid-level Practitioners)** _____
Prescriber Signature (No Stamps) (Substitution Permissible) _____ **Date (mm/dd/yyyy)** _____

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SECTION 5 – Patient Certifications

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

I am enrolling in KevzaraConnect® (the “Program”) and authorize Sanofi US, Regeneron Pharmaceuticals, Inc., and their affiliates, agents, and service providers (the “Alliance”) to provide me with services under the Program. Such services include disease education, facilitating access to KEVZARA, adherence communications and support, insurance benefits verification, coverage and financial assistance support, which may include free product provided by Sanofi Cares North America, a 501(c)(3) charitable organization, product information, and other support services (the “Services”).

Use of Sensitive Personal Information

I understand that my health information, contact information, and other sensitive personal information that I, my healthcare provider, and others share with the Alliance is collected to provide me with the assistance I request for the purposes described in this application and for other commercial purposes of the Alliance, as described in Regeneron’s Privacy Notice, available at regeneron.com/privacy-policy; Regeneron’s Consumer Health Data Privacy Policy, available at regeneron.com/privacy-policy; and Sanofi’s US Global Privacy Policy, available at sanofi.com/our-responsibility/sanofi-global-privacy-policy. Further, I understand that my consent is required to process my sensitive personal information under certain US state privacy laws and, by signing this form, I consent to the collection, use, disclosure, and processing of my personal and sensitive personal information, including my personal health data, as described herein and within the privacy notice.

I understand that I have the right to withdraw my consent at any time by notifying the Alliance using the contact information below. Depending on where I live, I may have certain rights with respect to my personal information, including the request to access or delete my personal information. I am aware that the Alliance may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact Regeneron’s Privacy Office by emailing dataprotection@regeneron.com or by calling [1-844-835-4137](tel:1-844-835-4137) or Sanofi’s Privacy Office by calling [866-553-8120](tel:866-553-8120) or emailing PrivacyOfficeUSA@sanofi.com.

Patient Financial Assistance

If I or a representative on my behalf requests financial assistance, which may include a request for free product from Sanofi Cares North America, I authorize KevzaraConnect® to verify my eligibility for the Patient Financial Assistance Programs, which may include accessing my credit information under the Fair Credit Reporting Act to estimate my income.

I certify that any financial information I provide is accurate and agree to notify Sanofi immediately if my insurance or financial status changes. I understand that, upon request, KevzaraConnect® will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it.

Conditions of Participation

I understand that no free product may be submitted for reimbursement to any third-party payer, including Medicare, Medicaid, VA, DOD, TRICARE, or similar federal program, and if approved for Medicare Part D assistance, I will not count program medication toward true-out-of-pocket (TROOP) costs. In addition, I agree to notify KevzaraConnect® if my insurance situation changes.

Patients whose health insurance benefits offer, or whose health insurance plans work with, an alternative funding program (AFP) are not eligible for KevzaraConnect®’s Patient Assistance Programs/need-based free drug. AFPs require patients with commercial plans to apply for patient assistance programs as a condition of, or requirement for, coverage by their commercial plan. By applying to a Sanofi Patient Assistance Program, you certify that your health insurance plan is not working with an AFP.

Communications Authorization

I authorize the Alliance to contact me by mail, telephone, or email with information about the Programs, disease state, and product information, services, research studies, and to ask my opinion on such information and topics, including market research and disease-related surveys (the “Communications”). I understand I may be contacted if I report an adverse event.

I am entitled to a signed copy of this authorization.

SECTION 6 – Patient 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, and any specialty pharmacies that dispense my medication (together, the “Disclosing Parties”) to disclose protected health information about me, including information related to my medical condition and treatment, health insurance coverage and claims, prescription information (including fill/refill information), and referral to and enrollment in the Program (together, “My Information”) to the Alliance for the purposes described in this Authorization.

Purposes of Disclosure

I permit the use and disclosure of My Information for the following purposes:

- Determining my eligibility for the Program and related support services
- Investigating my health insurance coverage benefits
- Assisting with prior authorization for coverage/reimbursement
- Assisting with appeals of denied claims for coverage/reimbursement
- Referring me to or determining my eligibility for financial assistance services including copay assistance services
- Coordinating my prescription through a pharmacy, infusion site, and/or healthcare provider’s office
- Providing me with ongoing therapy support and education
- Operating and administering the Program Services for which I am eligible

In support of the purposes above, the Alliance may de-identify My Information and use it in performing research, education, business analytics, and marketing studies, and also for other commercial purposes, including linkage with other de-identified information the Alliance may receive from other sources. I understand that members of the Alliance may share My Information among themselves to de-identify it for these purposes and as needed to perform the Services or to communicate with me.

Your Rights Under the Disclosure

I understand that once My Information has been disclosed to the Alliance, federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 in this Authorization or as otherwise required by law. I also understand and agree that:

- This Authorization expires 5 years from the date support is last provided under the Program, or until my local state law requires expiration, subject to applicable law, unless I withdraw it earlier. For patients with Maryland healthcare providers, this authorization expires 1 year from the date of signature
- I may withdraw (take back) this Authorization at any time by contacting Regeneron’s Privacy Office by emailing dataprotection@regeneron.com or by calling [1-844-835-4137](tel:1-844-835-4137) or Sanofi’s Privacy Office by calling [866-553-8120](tel:866-553-8120) or emailing PrivacyOfficeUSA@sanofi.com. Withdrawal of this Authorization will end my participation in the Program and will not affect any use or disclosure of My Information made before my request is received and processed
- I do not have to sign this Authorization. A decision not to sign will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits, or access to medication. However, if I do not sign this Authorization, I will not be able to participate in KevzaraConnect®
- I may have certain rights under applicable data privacy laws regarding My Information, including the right to access My Information held by the Alliance. For further information regarding these rights, please reference Regeneron’s Privacy Notice, available at regeneron.com/privacy-policy; Regeneron’s Consumer Health Data Privacy Policy, available at regeneron.com/privacy-policy; and Sanofi’s US Global Privacy Policy, available at sanofi.com/our-responsibility/sanofi-global-privacy-policy
- My pharmacy, health insurers, and third-party vendors may receive remuneration (payment) from the Alliance in exchange for disclosing My Information and/or providing me with support services
- I am entitled to a signed copy of this authorization