

Patient to Fill Out

Section 1. Patient Information

Patient name (first, MI, last) _____ Alternate phone (_____) _____ Preferred # Voicemail
Address _____ Mobile phone (_____) _____ Preferred # Voicemail
City _____ State _____ ZIP _____ I have read the Text Messaging Consent in Section 9 and expressly consent to receive text messages by or on behalf of the Program
DOB (mm/dd/yyyy) _____ Gender F M Email _____
Preferred patient language (if not English) _____

Patient Authorization

I have read and agree to the Patient Authorization to Use and Disclose Health Information included in Section 8 I have read and agree to the Patient Certifications included in Section 9

Sign **Sign**
Patient signature/Legal representative _____ Date (mm/dd/yyyy) _____ Patient signature/Legal representative _____ Date (mm/dd/yyyy) _____
If signed by a legal representative: _____ If signed by a legal representative: _____
Print name _____ Relationship to patient _____ 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 _____ Primary Rx insurance name (if different) _____
Insurance phone (_____) _____ Secondary insurance card attached
Policy ID # _____ Rx insurance phone (_____) _____
Group # _____ Policy ID # _____
Policy holder name (first/last) _____ Group # _____
Relationship to patient _____ Rx BIN # _____ Rx PCN # _____

Section 3. Prescriber Information

Prescriber name _____ Site/facility name _____
Prescriber NPI # _____ Group tax ID # _____ Office contact name _____
Specialty _____ Office contact email _____
Address _____ Phone (_____) _____
City _____ State _____ ZIP _____ Fax (_____) _____

Section 4. Diagnosis 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.____ L20.____ Years since diagnosis _____
 Primary diagnosis Secondary diagnosis
 Patient has moderate-to-severe AD that is inadequately controlled on prior or current topical therapy*
Severity: BSA involved under 10% 10% or more
Scoring tool name _____
Sensitive areas affected (Check all that apply.) hands feet face and neck
 genitals/groin scalp intertriginous areas other _____
*Moderate-to-severe AD is defined as moderate-to-severe erythema and moderate-to-severe papulation/infiltration.
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.____ J45.____ Years since diagnosis _____
 Primary diagnosis Secondary diagnosis
 Patient has moderate-to-severe asthma that requires add-on maintenance treatment
Eosinophil levels (if available) _____ cells/mcL Test date _____
 Atopic comorbidities
IgE level (if available) _____ Test date _____
Number of severe exacerbations in the past 12 months _____

Please see full indications on next page.
AD=atopic dermatitis; BSA=body surface area; ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification; IgE=immunoglobulin E.

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.

Moderate-to-severe atopic dermatitis
Rx: **DUPIXENT**® (dupilumab) 300 mg/2 mL, prefilled syringe, 2 pack
Initial dose (one time):
 600 mg SIG: 2 injections subcutaneously on Day 1
Maintenance:
 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: _____

Moderate-to-severe asthma with eosinophilic phenotype or oral corticosteroid dependent asthma
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 **Sign**
Prescriber signature (No stamps) _____ Dispense as written _____ Date (mm/dd/yyyy) _____ Collaborating MD name _____ NPI # _____
(Nurse practitioner/physician assistant 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.

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

Patient Name _____

Prescriber Name _____ NPI# _____

INDICATIONS

Atopic Dermatitis: DUPIXENT is indicated for the treatment of adult patients 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.

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.

Prescriber 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.

Patient to Fill Out

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



Please [click here](#) for full Prescribing Information.



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 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, 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.

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

SANOFI GENZYME  **REGENERON**

Please [click here](#) for full Prescribing Information.

US-DUP-1006

DUPIXENT® 
(dupilumab)

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:

^aI 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.

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

SANOFI GENZYME  **REGENERON**

Please [click here](#) for full Prescribing Information.

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DUPIXENT® 
(dupilumab)