KEVZARAConnect®

KEVZARA® (sarilumab)

Option 1: Complete and fax page 1 to KevzaraConnect® at 1-844-538-8960.
Option 2: Complete and upload page 1 to the Patient Support Portal (www.patientsupportnow.org 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)*** _____ Gender ☐ M ☐ F ☐ Other

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 _____

Rx insurance phone (_____) _____

Policy ID # _____ Group # _____

Rx BIN # _____ Rx PCN # _____

Primary medical insurance name _____

Insurance phone (_____) _____

Policy ID # _____ Group # _____

Policyholder name (first/last) _____

Relationship to patient _____

PATIENT AUTHORIZATION
I have read and agree to the Patient Certifications included in Sections 5 and 6.

Sign _____ _____
Patient Signature/Legal Representative Date (mm/dd/yyyy)

If signed by a legal representative

_____ _____
Printed Name Relationship to Patient

PLEASE NOTE: Both the Patient and 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 _____ _____
Patient Signature/Legal Representative Date (mm/dd/yyyy)

If signed by a legal representative

_____ _____
Printed Name Relationship to Patient

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 syringe, 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**_____

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 KEVZARA is medically necessary. I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification, medical and insurance information, and I understand that my patient's information provided to Sanofi US, Regeneron Pharmaceuticals, Inc., and their affiliates and agents (the "Alliance"), is for the use of KevzaraConnect solely to verify my patient's insurance coverage, to assess, if applicable, my patient's eligibility for patient assistance, and to otherwise administer KEVZARA for the patient. I request that KevzaraConnect conduct a benefit investigation for my patient and authorize KevzaraConnect to act on my behalf for the limited purposes of transmitting this prescription to the pharmacy. 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 KevzaraConnect contacting me by fax, mail, or email to provide additional information about KEVZARA injection or KevzaraConnect, and that KevzaraConnect 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.

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 and agents (together, the "Alliance") to provide me services under the Program, as described in this program enrollment form and as may be added in the future. Such services include medication and adherence communications, coverage, and financial assistance support.

I agree that the Alliance and its agents may use and share with my healthcare providers, specialty pharmacies, and insurers information about me in connection with the Services.

I authorize the Alliance to contact me by mail, telephone, or email, with information about the Program, the applicable disease, 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, as well as to contact me by mail, telephone, email, or text with disease information or with information about Alliance products, promotions, services or research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. 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 that I may be contacted by the Alliance in the event that I report an adverse event.

I authorize the Alliance under the Fair Credit Reporting Act to use my 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 understand that I do not have to enroll in the Program or receive the Communications and that I can still receive KEVZARA (sarilumab) injection, as prescribed by my physician. I may opt out of receiving Communications, individual support services offered by the Program, including the KEVZARA Patient Support Copay Card, or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1-844-KEVZARA (844-538-9272). I also understand that the Services may be revised, changed, or terminated at any time.

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 to disclose health information related to my medical condition, treatment, insurance coverage, and referral to and enrollment in the Program (collectively, my "Information") that is needed to enroll me in and provide me with the Services under the Program, and for the purposes of allowing the Alliance to send the Communications described in the Patient Certifications above.

I understand that the pharmacy that is dispensing my KEVZARA medication may receive payment from the Alliance for the expense of putting together and sending data about its dispensing of KEVZARA to me.

Once my Information has been disclosed to a third party, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that 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 KevzaraConnect Program. **I understand that this Authorization expires 5 years from the date support is last provided under the Program**, or until my local law requires expiration, subject to applicable law, unless and until I withdraw (take back) this Authorization before then, or as otherwise required by law. I may change my mind and cancel this Authorization at any time by calling 1-844-538-9272. I understand that canceling this Authorization will end my participation in the Program and will not affect any use or disclosure of the Information made before my request is received and processed. I understand that I may request a copy of this Authorization.