KEVZARAConnect®

Phone: 1-844-KEVZARA (1-844-538-9272) Option 1
Fax: 1-844-538-8960

Copay Card Program Reimbursement Form

If you have paid your copay in full in the last 90 days, **you may be eligible for reimbursement** of certain product-specific copay, co-insurance or deductible costs directly and actually incurred for a prescription for **KEVZARA® (sarilumab)** under the **KevzaraConnect** Copay Card Program.

Reimbursement is subject to program terms and conditions. Payment of the reimbursement is also subject to verification. Submission of this form is not a guarantee of payment.

Patient Information – please print

First Name _____ Middle _____ Last Name _____

Address 1 _____ Address 2 _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Date of Birth _____ Gender ☐ Male ☐ Female

Reimbursement Process

Please fill out all fields on this form completely and include the items listed below. Forms submitted without these items will not be eligible for reimbursement. Forms will generally take 7 to 10 business days to process.

- **Attach a copy of KEVZARA prescription label** (prescription receipt from the pharmacy that includes name and address of pharmacy, dosing, and days' supply)
- **Fill in the following information** in the boxes below, or provide a copy of the front of your copay card. See image at right for reference

Group #: E C ☐☐☐☐☐☐☐☐☐

Member ID: ☐☐☐☐☐☐☐☐☐☐☐☐

- **Include patient signature and certification** (see below)

Submit reimbursement request and attachments via mail or fax.

Mail: **KEVZARA** Copay Reimbursement Program, 200 Jefferson Park, Whippany, NJ 07981 **-OR-** **Fax:** **1-908-809-6249**

I, **(insert name)** _____, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the product-specific copay, co-insurance, or deductible expenses requested for reimbursement were actually incurred. My prescription for **KEVZARA** was not paid in whole or in part by Medicare, Medicaid, Veterans Affairs, Department of Defense, TRICARE, or any federal or state programs including any state pharmaceutical assistance program.

Patient Signature _____

If you have questions about the **KevzaraConnect** Copay Card or you wish to discontinue your participation, please contact us at **1-844-218-0444**, 24 hours a day, 7 days a week.

Please click here for full Prescribing Information, including risk of SERIOUS SIDE EFFECTS and Medication Guide.

SANOFI GENZYME REGENERON

KEVZARA® (sarilumab) injection
200 mg | 150 mg