LIBTAYO SURROUND® Enrollment Form

Fax: 1.833.853.8362 **Phone: 1.877.LIBTAYO** (1.877.542.8296) **Option 1**

To prevent delays, complete all fields and fax **ALL 4 PAGES** to the number above. For additional assistance, call us at **1.877.LIBTAYO** (1.877.542.8296) **Option 1**, Monday–Friday, 8 AM–8 PM Eastern time.

Please make sure to fill out all fields completely and fax all pages to 1.833.853.8362

SECTION 1 Support Requested (Check all that apply)

☐ Reimbursement (benefits investigation, prior authorization, appeals) ☐ Financial Assistance (copay, Patient Assistance Program [PAP]) ☐ Claims Assistance ☐ Nurse Support

SECTION 2 Patient Information

☐ Patient contact information attached

First Name _____ Middle Initial _____ Last Name _____ Gender ☐ Male ☐ Female Date of Birth _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ ☐ Preferred Phone OK to Leave Detailed Message? ☐ Yes ☐ No Best Time to Call _____ ☐ AM ☐ PM Email _____

Cell Phone _____ ☐ Preferred Phone OK to Leave Detailed Message? ☐ Yes ☐ No Best Time to Call _____ ☐ AM ☐ PM

Patient's Preferred Language (if not English) _____ Alternate Contact/Caregiver Name _____ Alternate Contact/Caregiver Phone _____

Patient Authorization

I have read and agree to enroll in LIBTAYO Surround and to the Patient Certifications included in Section 9

Sign _____ _____/_____/_____

Patient Signature/Legal Representative MM DD YYYY

I have read and agree to the Authorization to Disclose/Use Health Information in Section 10

Sign _____ _____/_____/_____

Patient Signature/Legal Representative MM DD YYYY

_____

Relationship to Patient (If signed by someone other than the patient, please describe your authority to sign on behalf of the patient)

SECTION 3 Patient Insurance Information

Does the patient have insurance (third-party or private insurance)? ☐ Yes ☐ No (If no, you can skip this question)

Primary Insurance
(Please include a copy of the front and back of your insurance card)

Primary Insurance Name _____

Primary Insurance Phone _____

Policyholder Name _____

Policy Number _____

Group Number _____

Policyholder's Relationship to Patient _____

Secondary Insurance
(Please include a copy of the front and back of your insurance card)

Secondary Insurance Name _____

Secondary Insurance Phone _____

Policyholder Name _____

Policy Number _____

Group Number _____

Policyholder's Relationship to Patient _____

SECTION 4 Prescribing Physician Information

Practice/Facility Name _____ Physician Name _____ Physician Specialty _____

Phone _____ Fax _____ Email _____

Address _____ City _____ State _____ ZIP _____

Physician's State Lic# _____ Physician's DEA# _____ Physician's PTAN _____

Physician's Tax ID# _____ Physician's National Provider Identifier (NPI) _____

Primary Office Contact Name _____ Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Email

Site of Service (Check only if patient will be referred to another site of care for administration)

☐ Physician Office ☐ Hospital Outpatient ☐ Ambulatory Surgical Center ☐ Hospital Inpatient ☐ Other

Name of site of service, if different from Practice/Facility Name above _____

SECTION 5 Treatment Information/Prescription *If applying for PAP, please attach any chart notes relevant to diagnosis, drug allergies, and current/prior therapies*

LIBTAYO® (cemiplimab-rwlc) ☐ Dispense: 350-mg vial Administer via intravenous infusion every_____weeks Refill:_____times

SECTION 6 Diagnosis

ICD-10-CM Diagnosis Code(s) _____

As a licensed health care professional, I certify that the patient named on this form has, or has had, a diagnosis for an FDA-approved indication for LIBTAYO ☐ Yes ☐ No

SECTION 7 Physician Certification

My signature below certifies that the person named on this form is my patient, the information provided on this application is complete and accurate to the best of my knowledge, and LIBTAYO received free of charge from the Patient Assistance Program in response to this application, if any, is exclusively for the patient named on this form. It is my professional judgment that LIBTAYO is a medically appropriate treatment for the patient named on this form. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, to provide the individually identifiable health information on this form to LIBTAYO Surround for purposes of researching my patient's health insurance coverage for LIBTAYO and assessing their eligibility for financial support programs offered through LIBTAYO Surround. I hereby certify that no medication received free of charge under the LIBTAYO Surround Patient Assistance Program shall be offered for sale, trade, or barter, and that no claim for reimbursement of either LIBTAYO or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer in connection with LIBTAYO provided for free under the Patient Assistance Program. I consent to Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (the "Alliance") contacting me by fax, phone, mail, or email to confirm receipt of LIBTAYO and/or to provide additional information about LIBTAYO or the LIBTAYO Surround Program. I understand that the Alliance may revise, change, or terminate any program services at any time without notice to me.

Sign _____ _____/_____/_____

MM DD YYYY

LIBTAYO® (cemiplimab-rwlc) Injection 350 mg

Complete entire form and fax **ALL 4 PAGES** to **LIBTAYO Surround** at **1.833.853.8362.**

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Patient Name _____

Prescriber Name _____ **NPI #** _____

SECTION 8 Financial Information (must be completed for PAP requests)

How many people live in your household? _____

What is your total annual household income?* _____

*Salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.

To qualify for the LIBTAYO Surround Patient Assistance Program, I understand that I must meet certain income and other eligibility requirements. LIBTAYO Surround 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 LIBTAYO Surround promptly if my insurance situation changes.

I also agree that Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together, the "Alliance") may verify my eligibility for the LIBTAYO Surround 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 for purposes of determining my income eligibility. 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.

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Patient Name _____

Prescriber Name _____ **NPI #** _____

SECTION 9 Patient Certifications

Please read the following carefully, then date and sign where indicated in Section 2 on page 1.

I am enrolling in the LIBTAYO Surround Program (the "Program") and authorize Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together, the "Alliance") to provide services to me under the program, as described in this Program Enrollment Form and as may be added in the future (the "Services").

I agree to my enrollment in the LIBTAYO Surround Copay Program if confirmed as eligible, understand that Copay information will be sent to my physician or the designated specialty pharmacy, and understand that any assistance with my applicable cost-sharing or copayment for LIBTAYO will be made in accordance with the Program terms and conditions.

If I am completing Section 8, I confirm my agreement with the conditions set forth in Section 8, and certify that the information I have set forth in Section 8, including 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, my condition, 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, including linkage with other de-identified information the Alliance receives from other sources. I understand that members of the Alliance may share health information about me, including information related to my medical condition, treatment with LIBTAYO, health insurance coverage, claims, prescription, and referral to and enrollment in the LIBTAYO Surround Program (together, "My 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 Information for these purposes and may share My Information with my healthcare providers and staff (together, "Health Care Providers"), my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies ("Specialty Pharmacies") that dispense my medication.

I understand that I do not have to enroll in the Program or receive the Communications, and that I can still receive LIBTAYO, as prescribed by my Health Care Provider. I may opt out of receiving Communications, individual support services offered by the Program, including the LIBTAYO Surround Copay Program, or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1.877.542.8296 or by sending a letter to LIBTAYO Surround, PO Box 220262, Charlotte, NC 28211-0262. I also understand that the Services may be revised, changed, or terminated at any time.

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

LIBTAYO® (cemiplimab-rwlc) Injection 350 mg

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Patient Name _____

Prescriber Name _____ **NPI #** _____

SECTION 10 Authorization to Disclose/Use Health Information

Please read the following carefully, then date and sign where indicated in Section 2 on page 1.

I authorize my healthcare providers and staff ("Health Care Providers"), my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies ("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, treatment with LIBTAYO, health insurance coverage, claims, prescription, and referral to and enrollment in the LIBTAYO Surround Program (together, "My Information"). My Health Care Providers, Health Insurers, Specialty Pharmacies, and the Alliance may use and disclose My Information for the purposes of providing certain support services, including:

- To determine if I am eligible to participate in LIBTAYO Surround reimbursement and coverage assistance program(s), Patient Assistance Programs, and other support programs (together, "LIBTAYO Surround Program");
- For the operation and administration of the LIBTAYO Surround Program;
- To investigate my health insurance coverage benefits;
- To obtain prior authorization for coverage/reimbursement;
- To assist with appeals of denied claims for coverage/reimbursement; and
- To refer me to, or to determine eligibility for, other programs and/or alternate sources of funding—such as Medicaid, healthcare exchanges, Medigap, state pharmaceutical assistance programs (SPAPs), and charitable foundations—that may be available to provide assistance to me with the costs of my medications.

I understand and agree that my Health Care Providers, Health Insurers, and Specialty Pharmacies 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 LIBTAYO or the LIBTAYO Surround 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 has agreed to protect My Information by using and disclosing it only for the purposes authorized in this Authorization or as otherwise required by law. I understand that I may be contacted by the Alliance in the event that I report an adverse event.

I understand that if I refuse to sign this Authorization, I will not be able to participate in the LIBTAYO Surround Program but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment, or my insurance enrollment or eligibility for insurance coverage.

Furthermore, I understand that I may withdraw (take back) this Authorization at any time by mailing or faxing a written request to LIBTAYO Surround at PO Box 220262, Charlotte, NC 28211-0262; Fax: 833.853.8362. Withdrawal of this Authorization will end my participation in the LIBTAYO Surround 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, Health Insurers, and Specialty Pharmacies.

This Authorization expires 18 months from the date support is last provided under any LIBTAYO Surround Program, subject to applicable law, unless I withdraw it earlier. I understand that I may request a copy of this Authorization.

For any questions or concerns, or to report side effects with a Regeneron and Sanofi product while enrolled in **LIBTAYO Surround**, please contact us at **1.877.LIBTAYO** (1.877.542.8296) **Option 1**, Monday–Friday, 8 AM–8 PM Eastern time.

REGENERON SANOFI GENZYME

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