myRARE® Start Form for Veopoz™ (pozelimab-bbfg)

Phone: 1-855-5VEOPOZ (1-855-583-6769) **Fax: 1-844-RAREFAX** (1-844-727-3329)

To prevent delays, complete all fields and **FAX ALL 4 PAGES** to **1-844-RAREFAX** (1-844-727-3329). For assistance, call us at **1-855-5VEOPOZ** (1-855-583-6769) Option 1, Monday–Friday, 9 AM–9 PM Eastern time.

Please make sure to fill out all the necessary information on pages 1 and 2, which is denoted by REQUIRED flags.

SECTION 1 Patient Information — REQUIRED

☐ Patient contact information attached

First name _____ Middle initial ____ Last name _____ DOB ____/____/_____ Gender ☐ M ☐ F ☐ Prefer not to disclose

Address _____ City _____ State _____ ZIP _____

Cell phone # (_____)_____ ☐ Preferred phone # OK to leave detailed message? ☐ Yes ☐ No Best time to call _____ ☐ AM ☐ PM

Home phone # (_____)_____ ☐ Preferred phone # OK to leave detailed message? ☐ Yes ☐ No Best time to call _____ ☐ AM ☐ PM

Patient's preferred language (if not English) _____ Email _____

Alternate contact/Caregiver name _____ Alternate contact/Caregiver phone # (_____)_____

Patient Consents

I have read and agree to enroll in myRARE® for VEOPOZ and to the Authorization to Disclose/Use Health Information included in **Section 8**

Sign (1 of 2) _____ Date (MM/DD/YYYY) _____

Patient signature/Legal representative

I have read and agree to enroll in myRARE for VEOPOZ and to the Patient Certifications included in **Section 9**

Sign (2 of 2) _____ Date (MM/DD/YYYY) _____

Patient signature/Legal representative

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

SECTION 2 Patient Insurance Information — REQUIRED

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

Primary Insurance

If copy of insurance card (front and back) is attached, check here ☐

Primary insurance name _____

Primary insurance phone # (_____)_____

Policy # _____

Group # _____

Policyholder name _____

Policyholder's relationship to patient _____

Secondary/Prescription Insurance (if applicable) ☐ Prescription insurance

If copy of insurance card (front and back) is attached, check here ☐

Secondary insurance name _____

Secondary insurance phone # (_____)_____

Policy # _____ BIN # _____

Group # _____ PCN # _____

Policyholder name _____

Policyholder's relationship to patient _____

SECTION 3 Prescribing Physician Information — REQUIRED

Physician Information

Name _____

Practice/Facility name _____

Address _____

City _____ State _____ ZIP _____

Phone # (_____)_____ Fax _____

National Practice Identifier (NPI) _____ Tax ID # _____

Group NPI _____

Primary Office Contact

(Who myRARE should contact to review patient coverage, collect missing information, and determine treatment setting and product acquisition.)

Name _____

Direct phone # (_____)_____ Fax _____

Email _____

Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Preferred day(s) of contact: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

Infusion Setting and Administration (Benefits will be provided based on indicated preferences and patient's plan coverage.)

Initial Loading Dose: Intravenous Infusion (one time)

Preferred Treatment Setting	Preferred Acquisition Channel
☐ Home	Specialty pharmacy with home infusion
☐ Clinical setting ☐ In-office ☐ Infusion center	☐ Buy-and-bill ☐ Specialty pharmacy to bill
☐ Undecided–Benefits information will be provided for available options based on plan coverage	

Maintenance Dose: Subcutaneous Injection (weekly)

Preferred Treatment Setting	Preferred Acquisition Channel
☐ Home	Specialty pharmacy with home infusion
☐ Clinical setting ☐ In-office ☐ Infusion center	☐ Buy-and-bill ☐ Specialty pharmacy to bill
☐ Undecided–Benefits information will be provided for available options based on plan coverage	

Name of preferred site of infusion, if different from practice/facility name above

_____

Address _____ City _____

State _____ ZIP _____ Phone # (_____)_____

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Please see accompanying full Prescribing Information, including Boxed WARNING, and Medication Guide.

07/2023 VEO.23.04.0003

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Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

SECTION 4 Diagnosis/Prescription — REQUIRED

Diagnosis: ☐ CHAPLE disease (*CD55*-deficient protein-losing enteropathy) ☐ Other _____

ICD-10-CM Diagnosis Code: D84.1 Defects in the complement system

REQUIRED **Patient weight in kg** _____

☐ Initial dose: Infusion prescription
Rx: VEOPOZ™ (pozelimab-bbfg) injection
Dose: 30 mg/kg IV one time
Infusion rate: 25 mg/hour to 250 mg/hour
Intended IV solution concentration: 6.7 mg/mL to 20 mg/mL

No refills

Infusion fluid type **(please select one)**:
☐ 0.9% saline injection _____mL
OR
☐ 5% dextrose injection _____mL

☐ Ongoing: Subcutaneous dose prescription
Rx: VEOPOZ™ (pozelimab-bbfg) injection
Dose: 10 mg/kg subcutaneously weekly
[Escalation dose: 12 mg/kg subcutaneously weekly]

30-day supply Refills _____

SECTION 5 Physician Certification — REQUIRED

☐ I confirm that I received and reviewed the Dear HCP Letter, Prescribing Information, and Medication Guide
☐ You have my permission to reach out to this patient to provide and review the Medication Guide and Patient Safety Card

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, in my professional judgment, therapy with VEOPOZ is medically necessary for the patient identified on this form. I understand that my patient's information provided to Regeneron Pharmaceuticals, Inc., and its affiliates and agents (together, "Regeneron") is for the use of myRARE® 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 myRARE for the patient including facilitating enrollment into the myRARE Program. 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 reimbursement support programs such as myRARE for these purposes. If applicable, I authorize myRARE to conduct a benefits investigation for my patient and 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, myRARE is authorized to transmit this prescription to a network pharmacy it selects. I certify that VEOPOZ received free of charge from the myRARE Patient Assistance Program in response to this application, if any, will be used exclusively for the patient named on this form. I also certify that no claim for reimbursement for free product or related medical procedures and services will be submitted to any payer, including Medicare and Medicaid; and no free product may be sold, traded, bartered or distributed for sale. I understand that any free product distributed through the myRARE Patient Assistance Program is not contingent on any purchase obligations. I consent to myRARE contacting me by fax, mail, or email to provide additional information about VEOPOZ or myRARE. I understand that Regeneron may revise, change, or terminate any program services at any time without notice to me.

Sign _____ **REQUIRED** _____ ☐ Dispense as written ☐ Substitution permitted

Physician signature Date (MM/DD/YYYY)

SECTION 6 Patient History

Diagnosis (Genetic AND Clinical)

☐ Genetic: Confirmation of *CD55* loss-of-function mutation
☐ Clinical: History of protein-losing enteropathy
Age at diagnosis: _____
History of hospitalizations in the past year?
☐ Yes ☐ No
If YES, how many days? _____

Surgical resection of intestines?
☐ Yes ☐ No
History of blood clots?
☐ Yes ☐ No
Family history of CHAPLE disease?
☐ Yes ☐ No

Clinical symptoms:
☐ Abdominal pain
☐ Diarrhea
☐ Facial edema
☐ Nausea
☐ Peripheral edema
☐ Vomiting

Pretreatment levels
Serum albumin levels (g/dL) _____
Immunoglobulin levels (mg/dL) _____
Vitamin B12 (pmol/L) _____
Alpha-1-antitrypsin (A1AT) _____

Previous and/or current treatments

Treatment name	Start date	Stop date	Current	Intolerant	Resistant
	_____/_____/_____	_____/_____/_____	☐	☐	☐
	_____/_____/_____	_____/_____/_____	☐	☐	☐
	_____/_____/_____	_____/_____/_____	☐	☐	☐
	_____/_____/_____	_____/_____/_____	☐	☐	☐
	_____/_____/_____	_____/_____/_____	☐	☐	☐
	_____/_____/_____	_____/_____/_____	☐	☐	☐
	_____/_____/_____	_____/_____/_____	☐	☐	☐

CHAPLE=*CD55* deficiency with hyperactivation of complement, angiopathic thrombosis and protein-losing enteropathy; ICD-10-CM=*International Classification of Diseases, Tenth Revision, Clinical Modification*; IV=intravenous.

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Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

SECTION 7 Financial Information (must be completed for Patient Assistance Program [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 myRARE® Patient Assistance Program, I understand that I must meet certain income and other eligibility requirements. myRARE 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 myRARE promptly if my insurance situation changes. I also agree that Regeneron Pharmaceuticals, Inc. and its affiliates, representatives, agents and contractors (together, "Regeneron") may verify my eligibility for the myRARE 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 Regeneron 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, Regeneron 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 Regeneron 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.

[Patients whose benefits include the use of an Alternate Funding Program are not eligible for Alliance Patient Assistance Programs/need-based free drug. Patients with insurance plans or employers who sign up with these alternate funding vendors will have no coverage for specialty drugs that are identified on a list determined by the alternate funding vendor and will be required to apply to a manufacturer patient assistance program or pursue specialty drug prescription coverage through the alternate funding program to obtain such specialty drugs, including Alliance products. I agree to inform the Alliance Patient Assistance Program team if I am a member of such an insurance plan or if I am applying to an Alliance Patient Assistance Program on behalf of a patient who is a member of such an insurance plan. Further, the Alliance Patient Assistance Program team may take additional steps to verify the patient assistance program need. Therefore, if I am applying to the Alliance Patient Assistance Program for either myself or on behalf of a patient, I authorize the Alliance Patient Assistance Program team to contact my/the patient's employer, insurer, and other third parties (such as pharmacy benefit managers and their affiliated partners) to verify prescription benefit design and coverage.]

SECTION 8 Authorization to Disclose/Use Health Information

Please read the following carefully, then date and sign where indicated in Section 1 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., and its affiliates and agents (together, "Regeneron") health information about me, including information related to my medical condition, treatment with VEOPOZ, health insurance coverage, claims, prescription, and referral to and enrollment in the myRARE Program (together, "My Information"). My Health Care Providers, Health Insurers, Specialty Pharmacies, and Regeneron may use and disclose My Information for the purposes of providing certain support services, including:

- To determine if I am eligible to participate in myRARE reimbursement and coverage assistance program(s), Patient Assistance Programs, and other support programs (together, "myRARE Program");
- For the operation and administration of the myRARE 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 Regeneron in exchange for disclosing My Information to Regeneron and/or for providing me with support services in connection with VEOPOZ or the myRARE Program. Once My Information has been disclosed to Regeneron, I understand that federal privacy laws may no longer protect it from further disclosure. However, Regeneron 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 Regeneron in the event that I report an adverse event. I understand that if I refuse to sign this, I will not be able to participate in the myRARE 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, faxing, or emailing a written request to myRARE at 1107 Nicholas Blvd, Elk Grove Village, IL 60007; fax: **1-844-RAREFAX** (1-844-727-3329); email: unsubscribe@regeneron.com. Withdrawal of this Authorization will end further uses and disclosures of My Information based on this Authorization made before my request is received and processed by my Health Care providers, Health Insurers, and Specialty Pharmacies. This Authorization expires 18 months from the date support is last provided under any myRARE Program, subject to applicable law, unless I withdraw it earlier. I understand that I may request a copy of this Authorization.

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Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

SECTION 9 Patient Certifications

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

I am enrolling in the myRARE® Program (the "Program") and authorize Regeneron Pharmaceuticals, Inc., and its affiliates, representatives, agents and contractors (together, "Regeneron") to provide services to me under the Program, as described in the Program Enrollment Form, such as coverage and reimbursement support, financial assistance, nurse education, and other support programs (the "Services"). I agree to my enrollment in the myRARE 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 VEOPOZ will be made in accordance with the Program terms and conditions. If I am applying for the Patient Assistance Program (PAP), I confirm my agreement with the conditions set forth, and certify that the number of people in my household and my household income are true and accurate to the best of my knowledge. If I am approved for the PAP, I certify that no claim for reimbursement will be submitted to any third-party payer for product I receive at no cost while I am enrolled in the Program. If I am enrolled in a Medicare Prescription Drug Plan, I acknowledge that the value of any free product I receive cannot be counted toward my True Out-of-Pocket (TrOOP) expenses and that Regeneron will notify my plan of the assistance received through the PAP. I authorize Regeneron to contact me by mail, telephone, email, or if I indicated my agreement and consent on page 1, with information about the Program, my condition, promotions related to VEOPOZ, brand opportunities, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize Regeneron to use my de-identified information for performing research, education, business analytics, marketing studies, or for other commercial purposes, including linkage with de-identified information about you from other sources (e.g., electronic health records, insurance and billing data, mobile devices, and genomic information) for research and analytics activities. As described in the Authorization to Disclose/Use Health Information, I understand that members of Regeneron may share health information about me, including information related to my medical condition, treatment with VEOPOZ, health insurance coverage, claims, prescription, and referral to and enrollment in the Program (together, "My Information"), with one another for these purposes and as needed to perform the Services or to send the communications listed above (the "Communications"). I understand and agree that Regeneron may use my health information for these purposes and may share My Information with my health care 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 VEOPOZ, as prescribed by my Health Care Providers. I may opt out of receiving Communications, individual support services offered by the Program, including the myRARE Copay Program, or opt out of the Program entirely, at any time by notifying a Program representative by: calling **1-855-5VEOPOZ** (1-855-583-6769); sending a letter to myRARE, 1107 Nicholas Blvd, Elk Grove Village, IL 60007; faxing **1-844-RAREFAX** (1-844-727-3329); or emailing unsubscribe@regeneron.com. I also understand that the Services may be revised, changed, or terminated at any time.

Other information about privacy practices

I understand that my health information, contact information, and other information that I, my healthcare provider, and others share with Regeneron Pharmaceuticals, Inc., and its affiliates and agents (together "Regeneron") is collected to provide me with the assistance I request and for other Regeneron business purposes, as described in its privacy notice, which is available at regeneron.com/privacy-notice. 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 Regeneron may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact the Privacy Office by emailing dataprotection@regeneron.com or by calling 1-844-835-4137.

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

Please see accompanying full Prescribing Information, including Boxed WARNING, and Medication Guide.

For any questions or concerns, or to report side effects with a Regeneron product while enrolled in myRARE, please contact us at **1-855-5VEOPOZ** (1-855-583-6769) Option 1, Monday–Friday, 9 AM–9 PM Eastern time.

REGENERON®

Veopoz™ (pozelimab-bbfg) Injection

777 Old Saw Mill River Road, Tarrytown, NY 10591 VEO.23.04.0003 07/2023