ENROLLMENT FORM
RETINOPATHY OF PREMATURITY

Fax: 1-888-335-3264
Phone: 1-855-EYLEA4U (1-855-395-3248), Option 4

EYLEA4U®
EYLEA® (aflibercept) Injection

Section 1.1: Support Requested (check only what applies)

☐ Benefits Investigation ☐ Copay Card Program (Commercial Patients)
☐ Prior Authorization Assistance ☐ Update Patient Record

Patient Assistance Program
☐ Patient Assistance Program (PAP)

Section 2.1: Patient Information

☐ Patient Contact Information Attached

First Name: _____ Middle Initial: ____ Last Name: _____ Gender: ☐ Male ☐ Female
Date of Birth: _____ Home Phone: _____ Cell Phone: _____ E-Mail: _____
Address: _____ City: _____ State: _____ ZIP: _____
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Section 2.2: Patient Insurance Information

Does the patient have insurance (third-party or private insurance)? ☐ Yes ☐ No

Primary Insurance (If copy of insurance card attached, check here ☐)
Payer Name: _____
Phone: _____
Policyholder Name: _____
Policy Number: _____
Employer/Group Number: _____

Secondary Insurance (If copy of insurance card attached, check here ☐)
Payer Name: _____
Phone: _____
Policyholder Name: _____
Policy Number: _____
Employer/Group Number: _____

Section 2.3: Patient Authorization and Certification

Date: _____

I have read and agree to the Authorization to Disclose/Use Health Information in 6.1

_____
(1 of 2) **Signature of legal representative if patient <18 years**

_____
Printed name of legal representative if patient is <18 years

I have read and agree to enroll in EYLEA4U® and to the Patient Certification included in Section 6.3

_____
(2 of 2) **Signature of legal representative if patient <18 years**

_____
Representative relationship to patient if patient is <18 years

Section 3.1: Treatment Information/Prescription

Dispense: ☐ Vial(s) NDC: 61755-0005-02
SIG: ☐ 0.4 mg (0.01 mL or 10 µL) administered by intravitreal injection

Section 4.1: Prescribing Physician Information

Site of Service: ☐ Physician Office ☐ Hospital Outpatient Practice/Facility Name: _____
Site National Provider Identifier (NPI): _____
Physician Name: _____ E-Mail: _____ Phone: _____ Fax: _____
Physician Specialty: _____ Address: _____ City: _____ State: _____ ZIP: _____
Physician's St Lic#: _____ Physician's DEA#: _____ Physician's PTAN: _____
Physician's Tax ID#: _____ Physician's NPI: _____

Section 4.2: Office Contact Information

Primary Office Contact: _____ Phone: _____ Fax: _____ E-Mail: _____

Section 4.3: Physician Certification

Must be signed by the physician for all Enrollment Form submissions.

My signature certifies the following: (i) that the person named on this Enrollment Form is my patient, (ii) that I have obtained his/her written authorization and certification under Section 2.3 of this form, (iii) that to the best of my knowledge the information, if applicable, under Section 6.2 of this form is accurate and complete, (iv) that I will retain in my files the complete patient-executed Enrollment Form, and (v) that upon request, I will promptly provide a copy of this patient-executed Enrollment Form on file to EYLEA4U.

My signature below 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 EYLEA received in response to this application is only for the use of EYLEA for the patient named on this form. With regard to any patient eligible for patient assistance through the EYLEA4U program, I acknowledge that this medication will not be offered for sale, trade, or barter and **EITHER** no claim for reimbursement of either EYLEA or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer **OR** I will provide appropriate denial and appeals documentation to support requests for patients who are deemed uninsured after a claim was submitted. I consent to Regeneron Pharmaceuticals, Inc. and its affiliates, representatives, agents, and contractors contacting me by fax, phone, mail, or email to confirm receipt of EYLEA or provide additional information about EYLEA or the EYLEA4U program and that Regeneron Pharmaceuticals, Inc. may revise, change, or terminate any program services at any time without notice to me. I authorize Regeneron Pharmaceuticals, Inc. and its representatives and contractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient, and I appoint the EYLEA4U program solely to convey the prescription herein on my behalf to the pharmacy chosen by or for the above-named patient.

Physician Signature: _____ **Date:** _____

Signature required; this form cannot be processed without an original or stamped signature.

Please see full Prescribing Information available at eyleahcp.us

Patient Name

First Name: _____ Middle Initial: ____ Last Name: _____

Section 5.1: Diagnosis (Select one as a primary diagnosis)

Retinopathy of Prematurity

	Right eye	Left eye	Bilateral	Unspecified eye
Retinopathy of prematurity, unspecified	☐ **H35.101**	☐ **H35.102**	☐ **H35.103**	☐ **H35.109**

	Right eye	Left eye	Bilateral	Unspecified eye
Retinopathy of prematurity, stage 0	☐ **H35.111**	☐ **H35.112**	☐ **H35.113**	☐ **H35.119**
Retinopathy of prematurity, stage 1 — demarcation line	☐ **H35.121**	☐ **H35.122**	☐ **H35.123**	☐ **H35.129**
Retinopathy of prematurity, stage 2 — intraretinal ridge	☐ **H35.131**	☐ **H35.132**	☐ **H35.133**	☐ **H35.139**
Retinopathy of prematurity, stage 3 — ridge with extraretinal fibrovascular proliferation	☐ **H35.141**	☐ **H35.142**	☐ **H35.143**	☐ **H35.149**
Retinopathy of prematurity, stage 4 — subtotal retinal detachment	☐ **H35.151**	☐ **H35.152**	☐ **H35.153**	☐ **H35.159**
Retinopathy of prematurity, stage 5 — total retinal detachment	☐ **H35.161**	☐ **H35.162**	☐ **H35.163**	☐ **H35.169**

☐ **Other** (*only available for PAP*) _____

Secondary diagnosis ☐☐☐.☐☐☐☐

Has patient started treatment? ☐ Yes ☐ No

Anticipated date of treatment: _____

Patient Name

First Name: _____ Middle Initial: ____ Last Name: _____

Section 6.1: Authorization to Disclose/Use Health Information

I authorize my health care providers and staff, my health insurer, health plan or programs that provide me health care benefits (together, "Health Insurers") and any specialty pharmacy(s) that dispense my medication to disclose to Regeneron Pharmaceuticals, Inc. and its affiliates, representatives, agents and contractors (together, "Regeneron") health information about me, including information related to my medical condition, treatment with EYLEA® (aflibercept) Injection, health insurance coverage, claims, prescription, and referral to and enrollment in the EYLEA4U® Programs (together, "My Information"). My health care providers, Health Insurers, specialty pharmacy(s) 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 Regeneron's reimbursement and coverage assistance program(s), patient assistance programs and other support programs (together, "EYLEA4U Programs");
- for the operation and administration of the EYLEA4U Programs;
- to investigate my health insurance coverage benefits;
- to obtain prior authorization for coverage/reimbursement;
- to assist with appeals of denied claims for coverage/reimbursement.

I understand and agree that my health care providers, Health Insurers and specialty pharmacy(s) may receive remuneration from Regeneron in exchange for disclosing My Information to Regeneron and/or for providing me with support services in connection with EYLEA or the EYLEA4U Programs. Once My Information has been disclosed to Regeneron, I understand that federal privacy laws may no longer protect it from further disclosure. However, Regeneron agrees 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 if I refuse to sign this Authorization, I will not be able to participate in the EYLEA4U Programs, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage.

Further, I understand that I may withdraw (take back) this Authorization at any time by mailing or faxing a written request to Regeneron at P.O. Box 220578, Charlotte, NC 28222-0578; Fax: (888) 335-3264. Withdrawal of this Authorization will end further uses and disclosures of My Information by the parties identified in this Authorization except to the extent those uses and disclosures have been made in reliance upon this Authorization.

This Authorization expires 18 months from the date support is last provided under any EYLEA4U Program, subject to applicable law, unless I withdraw it earlier. I understand that I may request a copy of this Authorization.

Section 6.2: Financial Information (must be completed for PAP requests)

How many people live in your household? _____

Total Annual Household Income (including salary/wages; Social Security income; disability income; any other income)*:

☐ $0 to $100,000 ☐ $100,001 to $150,000 ☐ Greater than $150,000

*Supporting documentation will be required. EYLEA4U may also ask for proof of income at any time for audit/verification.

Please complete this application and submit by fax to 1-888-335-3264.

Patient Name

First Name: _____ Middle Initial: ____ Last Name: _____

Section 6.3: Patient Certification

By signing, I am enrolling in the EYLEA4U® Programs, and authorize Regeneron to provide me with the EYLEA4U Programs. I verify that the information on this application and other supporting documentation is complete and accurate. I also verify that unless I have identified otherwise in this application, I have no other coverage for prescription medications, including Medicaid, Medicare or any public or private assistance programs, or any other form of insurance.

I also agree that Regeneron may verify my eligibility for the EYLEA4U Programs, and I understand that such verification may include contacting me or my health care 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. 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, if applicable.

I authorize Regeneron to contact me by mail, telephone, or email, with information about the EYLEA4U Programs, FDA-approved indications of EYLEA® (aflibercept) Injection, related disease state information 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 Regeneron to de-identify my health information and use it in performing research, education, business analytics, marketing studies or for other commercial purposes. I understand that members of Regeneron may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the EYLEA4U Programs 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 health information with my doctors, specialty pharmacies, and insurers.

In connection with administering the EYLEA4U Programs, I understand that Regeneron may contact me or my health care provider directly to confirm receipt of medications or to provide other information related to the EYLEA4U Programs. I also understand that Regeneron may revise, change or terminate the EYLEA4U Programs at any time.

I understand that I do not have to enroll in the EYLEA4U Programs or receive the Communications, and that I can still receive EYLEA as prescribed by my physician. I may opt out of receiving Communications, individual programs offered by the EYLEA4U Programs or opt out of the EYLEA4U Programs entirely at any time by mailing or faxing a written request to Regeneron at P.O. Box 220578, Charlotte, NC 28222-0578; Fax: (888) 335-3264.

Please complete this application and submit by fax to 1-888-335-3264.

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