LIBTAYO SURROUND®

# Enrollment Form

To prevent delays, fill out all fields **completely** and submit the Enrollment Form via 2 convenient options:
• **Fax** to **1.833.853.8362** • **Upload** through LIBTAYO Surround DocuSend at **www.patientsupportnow.org** (code: 8338538362)
For additional assistance, call us at **1.877.LIBTAYO** (1.877.542.8296) **Option 1**, Monday–Friday, 8 AM–8 PM Eastern time.

Upon enrollment, LIBTAYO Surround will conduct a **benefits investigation**; provide **prior authorization and appeals support for LIBTAYO**, if needed; and **explore financial assistance options** for eligible patients who need help with the out-of-pocket cost of LIBTAYO.

## SECTION 1 Patient Information

* = REQUIRED FIELD

☐ Patient contact information attached

First Name* _____ Middle Initial _____ Last Name* _____ Sex ☐ Male ☐ Female ☐ Other_____ 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

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

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

Sign _____ _____/_____/_____
Patient Signature/Legal Representative MM DD YYYY

☐ **I have read the Text Messaging Consent in Section 9 and expressly consent to receive text messages by or on behalf of the Program.**

## SECTION 2 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 3 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 Collaborating Physician (if applicable) _____

**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 4 Treatment Information/Prescription

*If applying for the Patient Assistance Program (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 5 Diagnosis

ICD-10-CM Diagnosis Code(s) _____

As a licensed healthcare 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 6 To be completed for patients with advanced NSCLC only

**Select 1:** LIBTAYO will be prescribed as monotherapy as per an FDA-approved indication ☐ **OR** LIBTAYO will be prescribed in combination with chemotherapy as per an FDA-approved indication ☐

If prescribed in combination with chemotherapy, LIBTAYO Surround will attempt to conduct a benefits investigation into the supplied chemotherapy agent: Agent_____ Dose_____ Schedule_____

Agent_____ Dose_____ Schedule_____

## SECTION 7 Physician Certification

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 LIBTAYO 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 LIBTAYO Surround 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 LIBTAYO Surround for the patient, including facilitating enrollment into the LIBTAYO Surround 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 LIBTAYO Surround for these purposes. I certify that LIBTAYO received free of charge from the LIBTAYO Surround 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 LIBTAYO Surround Patient Assistance Program is not contingent on any purchase obligations. I consent to LIBTAYO Surround contacting me by fax, mail, or email to provide additional information about LIBTAYO or LIBTAYO Surround. I understand that Regeneron may revise, change, or terminate any program services at any time without notice to me.

Sign _____ _____/_____/_____
**Wet signature required; stamped signatures cannot be accepted.** MM DD YYYY

Complete entire form and **fax** to LIBTAYO Surround at **1.833.853.8362** or **upload** via LIBTAYO Surround DocuSend at **www.patientsupportnow.org** (code: 8338538362).


LIB.23.01.0093 02/2023



LIBTAYO® (cemiplimab-rwlc) Injection 350 mg

**Patient Name** _____

**Prescriber Name** _____ **NPI #** _____

## SECTION 8 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 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., and its affiliates, representatives, agents, and contractors (together, "Regeneron") 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 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 for the Patient Assistance Program. 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 it obtains from public and other sources, including the use of third parties to conduct services that may improve the cross-border processing of my personal data outside the US, to estimate my income in conjunction with the Patient Assistance Program eligibility determination process.

**Patient Authorization**

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)





LIB.23.01.0093 02/2023



LIBTAYO® (cemiplimab-rwlc) Injection 350 mg

**Patient Name** _____

**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 LIBTAYO Surround Program (the "Program") and authorize Regeneron Pharmaceuticals, Inc., and its affiliates and agents (together, "Regeneron") to provide services to me under the Program, as described in this Program Enrollment Form, such as coverage and reimbursement support, financial assistance, education, and other support programs (the "Services").

I agree to my enrollment in the LIBTAYO Surround Commercial 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 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. I authorize Regeneron to contact me by mail, telephone, or email, or, if I indicate my agreement and consent on page 1, by text,* with information about the Program, my condition, promotions related to LIBTAYO 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 me from other sources (eg, 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 section, I understand that members of Regeneron 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 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 Information for these purposes and may share My Information with my healthcare providers and staff (together, "Healthcare 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 Healthcare Provider. I may opt out of receiving Communications, individual support services offered by the Program, including the LIBTAYO Surround Commercial Copay Program or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1.877.542.8296, by sending an email to unsubscribe@regeneron.com, 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.

**Other information about privacy practices**

I understand that my health information, contact information, and other information 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 www.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.

**Text messaging consent:**

*I acknowledge that by checking "Yes" in the Text Messaging Consent box on page 1, I expressly consent to receive text messages from or on behalf of the Program at the mobile telephone number(s) that I provide.

I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify Regeneron promptly if any of my number(s) change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by texting [SMSSTOP to 59179] from my mobile phone, and that I can get help for text messages by texting [SMSHELP to 59179]. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. Message and data rates may apply.

I understand that my consent is not required as a condition of purchasing any goods or services from Regeneron Pharmaceuticals, Inc., or its affiliates.

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

**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 1 on page 1.**

I authorize my healthcare providers and staff ("Healthcare 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 LIBTAYO, health insurance coverage, claims, prescription, and referral to and enrollment in the LIBTAYO Surround Program (together, "My Information"). My Healthcare 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 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 Healthcare 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 LIBTAYO or the LIBTAYO Surround 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 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, faxing, or emailing a written request to LIBTAYO Surround at [PO Box 220262, Charlotte, NC 28211-0262]; fax: 833.853.8362; 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 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 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

LIBTAYO® (cemiplimab-rwlc) Injection 350 mg