EYLEA4U®
EYLEA® HD (aflibercept) Injection 8 mg | EYLEA® (aflibercept) Injection 2 mg

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

Patient Assistance Program—Product Request Form (PRF)

The EYLEA4U® Patient Assistance Program (PAP) was designed to help eligible patients who have unmet medical needs, are uninsured, or lack coverage receive EYLEA® HD (aflibercept) Injection and/or EYLEA® (aflibercept) Injection free of charge.

⇨ ***All fields are required or shipping delays may occur*** ⇦

Section 1

Patient name: _____ Patient DOB: _____/_____/_____

RE # (If known): R E ☐☐☐☐☐☐☐

☐ By checking this box, I attest I am not aware of any changes in my patient's insurance coverage (including Medicaid or other state programs) and/or financial status. **PLEASE NOTE:** *If this box remains unchecked, PAP product shipment **will** be delayed.*

Section 2

Is patient transitioning from <u>EYLEA to EYLEA HD</u> or <u>EYLEA HD to EYLEA</u>?

☐ Yes (Proceed to Section 3)
☐ No (Proceed to Section 4)

Section 3 *Required if "Yes" is selected in Section 2*

Patient is transitioning product and is:

UNINSURED

⇩

Continue to Section 5

OR

INSURED

STOP!

» **A new EYLEA4U Enrollment Form for PAP is required if your patient is transitioning product**

AND

» **Additional PAP approval is required prior to product shipment**

Section 4 *Required if "No" is selected in Section 2*

Is the patient still receiving product?

☐ Yes, the patient continues to receive <u>current</u> product. *Continue to Section 5.*

☐ No, the patient is no longer receiving product. **Please disenroll the patient from PAP**.
OR
☐ No product shipment needed at this time. **Please send me PRF as a reminder on this date: _____**

EYLEA® HD (aflibercept) Injection 8 mg | EYLEA® (aflibercept) Injection 2 mg

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

Section 5 *(Re-enter patient information)*

Patient name: _____ Patient DOB: _____ /_____ /_____

RE# (If known): R E ☐☐☐☐☐☐☐

Section 6

PAP shipping options – please choose **ONE** option below (**unless** patient is receiving bilateral treatment **and** a different PAP-approved product in each eye)

If choosing a "Proactive PAP (upfront)" option below, please return this PRF a ***minimum of 10 business days before*** *the date of treatment to ensure product is delivered prior to the treatment date.*

EYLEA® HD

☐ **Proactive PAP (upfront)**

EYLEA4U® will deliver a PAP-labeled product to practice or site of treatment in advance of the patient's next scheduled date of treatment.

Next anticipated date of treatment: _____

EYLEA HD available in vial only

☐ **Reactive PAP (replacement)**

Physician treated patient with existing inventory. Requesting replacement for administered product to a PAP-approved patient.

	Left eye	*Right eye*
Injection date:		
Lot #:		

EYLEA HD available in vial only

EYLEA®

☐ **Proactive PAP (upfront)**

EYLEA4U will deliver a PAP-labeled product to practice or site of treatment in advance of the patient's next scheduled date of treatment.

Next anticipated date of treatment: _____

A PFS will be delivered by default, unless the box below is marked:

☐ Please deliver a vial instead of a PFS

☐ **Reactive PAP (replacement)**

Physician treated patient with existing inventory. Requesting replacement for administered product to a PAP-approved patient.

	Left eye	*Right eye*
Injection date:		
Administered:	☐ PFS *or* ☐ Vial	☐ PFS *or* ☐ Vial
Lot #:		

PFS = pre-filled syringe.

EYLEA 4U®
EYLEA® HD (aflibercept) Injection 8 mg | EYLEA® (aflibercept) Injection 2 mg

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

Section 7 *(Re-enter patient information)*

Patient name: _____ Patient DOB: _____/_____/_____

RE # (If known): R E ☐☐☐☐☐☐☐

Section 8

Shipping address:

Account Name: _____ Attn: _____

Street: _____

City: _____ State: _____ ZIP: _____

Acceptable delivery days: ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Any of these days

Section 9

☐ **By checking this box, I attest both that product was/will be administered to a PAP-approved patient and the site will not seek payment or reimbursement for product administered for this PAP patient from any patient, government health care program, or third-party payer.**

Physician's signature: _____ **Date:** _____
***Signature required**; this form cannot be processed without an original or stamped signature.*

Please fax the completed form to 1-888-335-3264. If you have any questions, please call EYLEA4U® at 1-855-EYLEA4U (1-855-395-3248), Option 4, Monday–Friday, 9 AM–8 PM Eastern Time.

All other consents, certifications, authorizations, representations, and obligations as described within the original EYLEA Enrollment Form shall remain in full force and effect unless otherwise noted and shall also apply to EYLEA HD.

This letter contains personal health care information from EYLEA4U and should only be viewed by the individual to whom it is addressed. Please contact EYLEA4U at 1-855-EYLEA4U (1-855-395-3248), Option 4, if you have received this letter in error. You may also return this letter to the EYLEA4U Patient Support Program at PO Box 220578, Charlotte, NC 28222-0578.

The EYLEA4U Patient Support Program is committed to protecting the confidentiality of individuals' health and financial information. EYLEA4U receives health information from health care providers, health plans, and health insurers pursuant to written authorizations from patients who have enrolled in EYLEA4U. EYLEA4U uses patients' health and financial information only to provide coverage and reimbursement, care coordination, support services, and for other purposes required by law or permitted by the EYLEA4U Enrollment Form. EYLEA4U does not share program participants' medical and financial records with Regeneron Pharmaceuticals, Inc.