KEVZARA connect® | **Patient Consent and Enrollment Form**

KEVZARA® (sarilumab) injection
200 mg | 150 mg

Instructions

To ensure your information is processed without delay:

1. Complete Section 1
2. Sign Section 2
3. If you are applying for financial assistance through the Patient Assistance Program, complete Section 3 and Section 4
4. Return all completed sections of this consent form

By mail
Connect
PO Box 220650
Charlotte, NC 28222
You may use the self-addressed, postage-paid envelope, if provided

Or by fax
1-844-538-8960

Section 1. Patient Information (*Required Fields)

Patient Name (First, MI, Last)* _____

Date of Birth* ____/____/____ Gender* ☐ Male ☐ Female ☐ Other _____ ☐ Prefer not to disclose

Email* _____

Mobile Phone* _____ ☐ Primary ☐ Voicemail ☐ Text message

Alternate Phone _____ ☐ Primary ☐ Voicemail ☐ Text message

Address _____

City _____ State _____ ZIP* _____

Preferred Patient Language (if not English) _____

Section 2. Patient Authorization

I have read and agree to the Patient Certifications in Section 5 on page 3.

☐ By checking this box, I confirm that I have read the Text Messaging Consent in Section 5 and expressly consent to receive text messages by or on behalf of the Program.

Sign _____ _____

Patient Signature/Legal Representative Signature | Date (mm/dd/yyyy)

_____ _____

Printed Name (if signed by a legal representative) | Relationship to Patient

I have read and agree to the Patient Authorization to Use and Disclose Health Information (HIPAA Consent) in Section 6 on page 4.

Sign _____ _____

Patient Signature/Legal Representative Signature | Date (mm/dd/yyyy)

_____ _____

Printed Name (if signed by a legal representative) | Relationship to Patient

Please see Indication and Important Safety Information on pages 5 and 6. Click here to see the full Prescribing Information including risk of SERIOUS SIDE EFFECTS and Medication Guide.

For assistance with completing this form, call **1-844-KEVZARA** (1-844-538-9272) Option 1, Monday–Friday, 8 AM–9 PM Eastern time

Instructions
Complete this page if you would like to apply for financial assistance through the KevzaraConnect Patient Assistance Program. **All fields are required.**

Patient Name (First, MI, Last) _____

Section 3. Prescriber Information

Healthcare Provider _____ **OR** Practice Name _____

City _____ State _____

Section 4. Household Income (required if applying for financial assistance)

How many people live in your household, including yourself? _____

What is your total annual household income? _____

Total annual household income includes annual gross salary/wages, Social Security income, unemployment insurance benefits, disability income, worker's compensation, and any other income for your household.

To qualify for the KevzaraConnect Patient Assistance Program, I understand that either (a) I do not have insurance coverage for the product prescribed or (b) I have coverage through my Medicare Part D plan. KevzaraConnect 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. Enrollment and continuation in the program is conditioned upon timely verification of income. In addition, I agree to notify KevzaraConnect 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 KevzaraConnect Patient Assistance 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. 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, if applicable. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale.

This page does not need to be returned; you may keep it for your records.

Section 5. Patient Certifications

(Please read the following carefully, then date and sign where indicated in Section 2 of page 1)

I am enrolling in KevzaraConnect (the "Program") and authorize Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together the "Alliance") to provide me services under the Program, as described in this Program Enrollment Form and as may be added in the future. Such services include medication and adherence communications and support, medication dispensing support, coverage and financial assistance support, disease and medication education, injection training and other support services (the "Services").

I agree to my enrollment in the KevzaraConnect Copay Card Program if confirmed as eligible, understand that Copay Card information will be sent to the designated specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or co-payment for KEVZARA® (sarilumab) injection will be made in accordance with the Program terms and conditions.

If I am completing Section 4, I confirm my agreement with the conditions set forth in Section 4, and certify that my household income is 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, rheumatoid arthritis (RA) 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 the Alliance to de-identify my health information and use it in performing research including linkage with other de-identified information the Alliance receives from other sources, education, business analytics, marketing studies or for other commercial purposes. I understand that members of the Alliance may share identifiable health 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 health information for these purposes and may share my health information with my doctors, specialty pharmacies, and insurers. I understand that I may be contacted by the Alliance in the event that I report an adverse event.

I understand that I do not have to enroll in the Program or receive the Communications, and that I can still receive KEVZARA (sarilumab) injection, as prescribed by my physician. I may opt out of receiving Communications, individual support services offered by the Program, including the KEVZARA Patient Support Copay Card, or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1-844-KEVZARA (844-538-9272), Option 1, or by sending a letter to KevzaraConnect, 1800 Innovation Point Fort Mill, SC 29715. I also understand that the Services may be revised, changed, or terminated at any time.

Text Messaging Consent:

I acknowledge that by checking 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 the Alliance 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 KEVSTOP to 39771 from my mobile phone, and that I can get help for text messages by texting KEVHELP to 39771. 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. I understand that my consent is not required as a condition of purchasing any goods or services from Regeneron Pharmaceuticals, Inc., Sanofi US, or their affiliates. Message and data rates may apply.

KEVZARA® (sarilumab) injection 200 mg | 150 mg

This page does not need to be returned; you may keep it for your records.

Section 6. Patient Authorization To Use And Disclose Health Information (HIPAA Consent)

(Please read the following carefully, then date and sign where indicated in Section 2 of page 1)

I authorize my healthcare providers and staff, my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any 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 and treatment, health insurance coverage and claims, prescription (including fill/refill information) related to my prescription for KEVZARA (sarilumab) injection therapy ("My Information"). I understand the disclosure to the Alliance will be for the purposes of enrolling me in and providing certain services, (collectively referred to as the "KevzaraConnect Program)," including

- to determine if I am eligible to participate in KevzaraConnect coverage assistance programs, patient assistance programs or other support programs (the "Program")
- to investigate my health insurance coverage for KEVZARA injection
- to obtain prior authorization for coverage
- to assist with appeals of denied claims for coverage
- for the operation and administration of the KevzaraConnect Program
- to refer me to, or to determine my eligibility for other programs, foundations or alternative sources of funding or coverage that may be available to provide assistance to me with the costs of my medication

I authorize and agree that the Alliance's field level employees may have access to My Information in order to assist the Alliance in providing support services in connection with the KevzaraConnect Program.

I understand and agree that my healthcare providers, Health Insurers, and specialty pharmacy(ies) 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 the KevzaraConnect 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, I also understand that the Alliance will protect My Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise allowed by law.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits or Alliance medications. However, if I do not sign this Authorization, I understand that I will not be able to participate in the KevzaraConnect Program.

I understand that this Authorization expires 18 months from the date support is last provided under the Program, subject to applicable law, unless and until I withdraw (take back) this Authorization before then, or as otherwise required by law. Further, I understand that I may withdraw this Authorization at any time by mailing or faxing a written request to KevzaraConnect at 1800 Innovation Point, Fort Mill, SC 29715; Fax: 1-844-538-8960. Withdrawal of this Authorization will end my participation in the KevzaraConnect 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 and staff, my Health Insurers and specialty pharmacy(ies).

I understand that I may request a copy of this Authorization.

Please see Indication and Important Safety Information on pages 5 and 6. Click here to see the full Prescribing Information including risk of SERIOUS SIDE EFFECTS and Medication Guide.

For assistance with completing this form, call **1-844-KEVZARA** (1-844-538-9272) Option 1, Monday–Friday, 8 AM–9 PM Eastern time

What is KEVZARA?

KEVZARA® (sarilumab) is an injectable prescription medicine called an Interleukin-6 (IL-6) receptor blocker. KEVZARA is used to treat adult patients with moderately to severely active rheumatoid arthritis (RA) after at least one other medicine called a disease modifying antirheumatic drug (DMARD) has been used and did not work well or could not be tolerated.

IMPORTANT SAFETY INFORMATION

KEVZARA can cause serious side effects including:

- **SERIOUS INFECTIONS: KEVZARA is a medicine that affects your immune system. KEVZARA can lower the ability of your immune system to fight infections. Some people have serious infections while using KEVZARA, including tuberculosis (TB), and infections caused by bacteria, fungi, or viruses that can spread throughout the body. Some people have died from these infections. Your healthcare provider should test you for TB before starting KEVZARA. Your healthcare provider should monitor you closely for signs and symptoms of TB during treatment with KEVZARA.**
- Before starting KEVZARA, tell your healthcare provider if you:
    - think you have an infection or have symptoms of an infection, with or without a fever, such as sweats or chills, muscle aches, cough, shortness of breath, blood in phlegm, weight loss, warm, red or painful skin or sores on your body, diarrhea or stomach pain, burning when you urinate or urinating more often than normal or feel very tired; or are being treated for an infection, get a lot of infections or have repeated infections
    - have diabetes, HIV, or a weakened immune system.
    - have TB, or have been in close contact with someone with TB
    - live or have lived, or have traveled to certain parts of the country (such as the Ohio and Mississippi River valleys and the Southwest) where there is an increased chance of getting certain fungal infections (histoplasmosis, coccidioidomycosis, or blastomycosis)
    - have or have had hepatitis
- After starting KEVZARA, call your healthcare provider right away if you have any symptoms of an infection.
- **CHANGES IN CERTAIN LABORATORY TEST RESULTS:** Your healthcare provider should do blood tests before and after starting KEVZARA to check for low neutrophil (white blood cells that help the body fight off bacterial infections) counts, low platelet (blood cells that help with blood clotting and stop bleeding) counts, and an increase in certain liver function tests. Changes in test results are common with KEVZARA and can be severe. You may also have changes in other laboratory tests, such as your blood cholesterol levels. Your healthcare provider should do blood tests 4 to 8 weeks after starting KEVZARA and then every 6 months during treatment to check for an increase in blood cholesterol levels.

Please see additional Important Safety Information on page 6.
Click here to see the full Prescribing Information including risk of SERIOUS SIDE EFFECTS and Medication Guide.

KEVZARA®
(sarilumab) injection
200 mg | 150 mg

IMPORTANT SAFETY INFORMATION (cont'd)

- **TEARS (PERFORATION) OF THE STOMACH OR INTESTINES:** Tell your healthcare provider if you have had a condition known as diverticulitis (inflammation in parts of the large intestine) or ulcers in your stomach or intestines. Some people using KEVZARA get tears in their stomach or intestine. This happens most often in people who also take nonsteroidal anti-inflammatory drugs (NSAIDS), corticosteroids, or methotrexate. Call your healthcare provider right away if you have fever and stomach (abdominal) pain that does not go away.
- **CANCER:** KEVZARA may increase your risk of certain cancers by changing the way your immune system works. Tell your healthcare provider if you have ever had any type of cancer
- **SERIOUS ALLERGIC REACTIONS:** Serious allergic reactions can happen with KEVZARA. Get medical attention right away if you have any of the following signs: shortness of breath or trouble breathing; feeling dizzy or faint; swelling of the lips, tongue, or face; moderate or severe stomach (abdominal) pain or vomiting; or chest pain.
- Do not use KEVZARA if you are allergic to sarilumab or any of the ingredients of KEVZARA.
- Before using KEVZARA, tell your healthcare provider if you:
    - have an infection
    - have liver problems
    - have had stomach (abdominal) pain or a condition known as diverticulitis (inflammation in parts of the large intestine) or ulcers in your stomach or intestines
    - recently received or are scheduled to receive a vaccine. People who take KEVZARA should not receive live vaccines.
    - plan to have surgery or a medical procedure
    - are pregnant or plan to become pregnant. It is not known if KEVZARA will harm your unborn baby
    - are breastfeeding or plan to breastfeed. Talk to your healthcare provider about the best way to feed your baby if you use KEVZARA. It is not known if KEVZARA passes into your breast milk.
    - take any medicines, including prescription and nonprescription medicines, vitamins, and herbal supplements. Especially tell your healthcare provider if you use
        - o any other medicines to treat your RA. Using KEVZARA with these medicines may increase your risk of infection.
        - o medicines that affect the way certain liver enzymes work. Ask your healthcare provider if you are not sure if your medicine is one of these.
- The most common side effects include:
    - injection site redness
    - upper respiratory tract infection
    - urinary tract infection
    - nasal congestion, sore throat, and runny nose

These are not all the possible side effects of KEVZARA. Tell your doctor about any side effect that bothers you or does not go away. You are encouraged to report side effects of prescription drugs to the FDA at www.fda.gov/medwatch or call 1-800-FDA-1088 or to Sanofi-Aventis at 1-800-633-1610.

To learn more, talk about KEVZARA with your healthcare provider or pharmacist. The FDA-approved Medication Guide and Prescribing Information can be found at www.KEVZARA.com or by calling 1-844-KEVZARA.

Please click here to see the full Prescribing Information including risk of SERIOUS SIDE EFFECTS and Medication Guide.

KEVZARA®
(sarilumab) injection
200 mg | 150 mg