LIBTAYO SURROUND®

Enrollment Form

To prevent delays, fill out all fields **completely** and submit the Enrollment Form via 2 options:
• **Fax** to **1.833.853.8362** • **Upload** through Docu-Send at **DocuSend.org**
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 *(Patient contact information can be attached)*

* = REQUIRED FIELD

First Name* _____ Middle Initial _____ Last Name* _____

Gender ☐ Male ☐ Female ☐ Other_____ Date of Birth* _____ Email _____

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) _____ Alternate Contact/Caregiver Name _____ Alternate Contact/Caregiver Phone _____

HIPAA Authorization

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

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)

Enrollment Into LIBTAYO Surround Program Services

I have read and agree to enroll in LIBTAYO Surround program services and to the Patient Certification included in Section 9 including, if applicable, that Regeneron may access my individual credit history from key reporting agencies.

Sign _____ _____/_____/_____

Patient Signature/Legal Representative **MM DD YYYY**

Consent to Collect Information for Marketing Purposes (Optional)

Read the *Consent to Collect Information for Marketing Purposes* on page 5 and then check the box below if you consent.

☐ **I consent**

Consent to Disclose Information for Marketing Purposes (Optional)

Read the *Consent to Disclose Information for Marketing Purposes* on page 6 and then check the box below if you consent.

☐ **I consent**

OK to Text? ☐ **Yes** ☐ **No** (By checking "Yes," I acknowledge that I have read the Text Messaging Consent in Section 9 and expressly consent to receive text messages by or on behalf of the Program.)

For more information on Regeneron's privacy practices, please read Regeneron's privacy policy, which is available at **regeneron.com/privacy-policy**

SECTION 2 | Patient Insurance Information

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

Primary Insurance

Primary Insurance Name _____

Primary Insurance Phone _____

Policyholder Name _____

Policy Number _____

Group Number _____

Policyholder's Relationship to Patient _____

Secondary Insurance

Secondary Insurance Name _____

Secondary Insurance Phone _____

Policyholder Name _____

Policy Number _____

Group Number _____

Policyholder's Relationship to Patient _____

SECTION 3 | 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.

Please see full Prescribing Information for LIBTAYO, available at LIBTAYOhcp.com.

Complete pages 1 - 2 and **fax** to LIBTAYO Surround at **1.833.853.8362** or **upload** via Docu-Send at **DocuSend.org**.

US.LIB.25.10.0079 10/25

LIBTAYO® (cemiplimab-rwlc) Injection 350 mg

LIBTAYO SURROUND®

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• **Fax** to **1.833.853.8362** • **Upload** through Docu-Send at **DocuSend.org**
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Patient Name* _____ Date of Birth* _____

Prescriber Name _____ NPI# _____

Request LIBTAYO Surround conduct an assessment for the PAP? ☐ Yes ☐ No

SECTION 4 | Prescribing Physician Information

Practice/Facility Name* _____ Primary Office Contact Name* _____

Phone* _____ Fax* _____ Email _____

Address* _____ City* _____ State* _____ ZIP* _____

Physician Name* _____ Physician's National Provider Identifier (NPI)* _____

Physician's Tax ID* _____ Physician's DEA# _____ Collaborating Physician (if applicable) _____

Site of Service* ☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other _____

Treating Facility's NPI* _____ Treating Facility's Tax ID* _____

Treating Practice/Facility Name (if different from Practice/Facility Name above) _____

SECTION 5 | Treatment Information (New York prescribers must submit the prescription via eRX, verbal order, or serialized prescription for the prescription to be valid)

LIBTAYO® (cemiplimab-rwlc) ☐ Dispense: 350-mg vial* Administer via intravenous infusion every _____ weeks* Refill: _____ times*

SECTION 6 | Diagnosis

ICD-10-CM Diagnosis Code(s)* _____

SECTION 7 | To be completed for patients with advanced NSCLC only

Check one:
☐ 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(s):

Agent _____ Dose _____ Schedule _____

Agent _____ Dose _____ Schedule _____

SECTION 8 | Physician Certification

Must be signed by the physician for all Enrollment Form submissions, including Provider Portal and Digital Enrollment.

My signature certifies that the person named on this form is my patient; the information on this form, 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 the LIBTAYO Surround program, and I authorize LIBTAYO Surround 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 further certify that I will retain in my files the complete patient-executed Enrollment Form, and that upon request, I will promptly provide a copy of this patient-executed Enrollment Form on file to LIBTAYO Surround.

I certify that LIBTAYO received free of charge from the LIBTAYO Surround PAP 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 and will otherwise comply with the LIBTAYO Surround PAP terms and conditions. I understand that any free product distributed through the LIBTAYO Surround PAP 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.

In connection with my participation in the LIBTAYO Surround Commercial Copay Program, I hereby represent and warrant that: a) I have verified that the patient does not have coverage for LIBTAYO under any state or federally funded healthcare program and has coverage for LIBTAYO under a commercial or private insurance plan and is receiving LIBTAYO for an FDA-approved indication; b) participation in the LIBTAYO Surround Commercial Copay Program is not inconsistent with laws and regulations applicable to my medical practice or with any contract or arrangement with any third-party payer to which I will submit a bill or claim for reimbursement of LIBTAYO administered to the patient; c) I will comply with applicable obligations, if any, to disclose the acceptance of such payment to the applicable payers; and d) the bill or claim I submit to the insurer or patient for payment is separate from any bill or claim outside of product and administration or any other items or services provided to the patient.

Sign _____ _____/_____/_____
MM DD YYYY

Wet signature required; stamped signatures cannot be accepted.*

Please see full Prescribing Information for LIBTAYO, available at LIBTAYOhcp.com.

Complete pages 1 - 2 and **fax** to LIBTAYO Surround at **1.833.853.8362** or **upload** via Docu-Send at **DocuSend.org**.

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LIBTAYO® (cemiplimab-rwlc) Injection 350 mg

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 and authorize Regeneron Pharmaceuticals, Inc., and its affiliates, representatives, agents, and contractors (together, "Regeneron") to provide me with assistance, as described in the Program Enrollment Form, such as coverage and reimbursement support, financial assistance, education, and other support programs (the "Program"). I agree that Regeneron may verify my eligibility for the Program, and I understand that such verification may include contacting me or my healthcare providers for additional information and/or reviewing additional financial, insurance, and/or medical information. I verify that the information on this form and other supporting documentation is complete and accurate to the best of my knowledge.

I agree to my enrollment in the LIBTAYO Surround Commercial Copay Program if confirmed as eligible 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. I understand that patients who are enrolled in any federal healthcare program, including, without limitation, Medicare, Medicaid, TRICARE, and Veterans Affairs are not eligible to participate in the LIBTAYO Surround Commercial Copay Program. I understand that the LIBTAYO Surround Commercial Copay Program is not health insurance.

Patients **are not eligible** for the LIBTAYO Surround Patient Assistance Program (PAP)/need-based free drug if their employer, insurance plan, payer, or third-party administrator participates in an alternate funding program and requires them to (i) apply to the LIBTAYO Surround PAP as a condition of, requirement for, or prerequisite to coverage of relevant Regeneron products, and/or (ii) denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or approval or denial of, eligibility for a manufacturer patient support program like the LIBTAYO Surround PAP. I (or my legally authorized representative or guardian) am applying for assistance from the LIBTAYO Surround PAP voluntarily. I have not been directed by my insurance plan, employer, payer, or any other third-party administrator to seek assistance from the LIBTAYO Surround PAP, and I agree to inform the LIBTAYO Surround PAP team if I am requested to apply to the LIBTAYO Surround PAP by my insurance plan, employer, payer, or any other third-party administrator.

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SECTION 9 | Patient Certifications (cont'd)

Further, I acknowledge that the LIBTAYO Surround PAP team may take additional steps to verify my eligibility for the PAP/need-based free drug. Therefore, if I am applying to the LIBTAYO Surround PAP for either myself or on behalf of a patient, I authorize the LIBTAYO Surround PAP 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. If I subsequently learn that my insurance plan, employer, payer, and/or other third-party administrator uses an alternate funding program, I agree to inform the LIBTAYO Surround PAP team immediately and understand that I will no longer be eligible for support.

To qualify for the LIBTAYO Surround PAP, 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 PAP. 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, including the use of third parties to conduct services that may improve the cross-border processing of my personal data outside of the US, to estimate my income in conjunction with the PAP eligibility determination process.

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SECTION 9 | Patient Certifications (cont'd)

If I am applying for the PAP, I confirm my agreement with the conditions set forth. If I am approved for the PAP or if I otherwise receive no cost product under the Program, I certify that neither I nor anyone acting on my behalf will seek reimbursement from any third-party insurer or 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 understand that I do not have to enroll in the Program, and that I can still receive LIBTAYO, as prescribed by my healthcare providers and staff. Participation in the Program does not obligate me to use any specific healthcare provider, and I am free to change providers at any time. I may opt out of individual support 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: calling 1.877.542.8296; sending a letter to LIBTAYO Surround, PO Box 220262, Charlotte, NC 28211-0262; faxing 1.833.853.8362; or emailing unsubscribe@regeneron.com. I also understand that I must inform the Program if my financial circumstance, insurance, or any other eligibility criteria changes. I also understand that the Program may be revised, changed, or terminated, in whole or in part, at any time and without notice.

Consent to Collect Information for Marketing Purposes

I authorize Regeneron to collect my Health Information to contact me with marketing communications about other Regeneron products and services. I understand I am not required to consent to collection of my Health Information for these marketing purposes, and I can still enroll in the Program even if I do not consent to receive marketing communications about other Regeneron products and services. If I consent, I have the right to withdraw my consent at any time.

SECTION 9 | Patient Certifications (cont'd)

Consent to Disclose Information for Marketing Purposes

I authorize Regeneron to disclose my Health Information to contact me with marketing communications about other Regeneron products and services. I understand that I am not required to consent to the disclosure of my Health Information for these marketing purposes, and I can still enroll in the Program even if I do not consent to disclose my Health Information to receive marketing communications about other Regeneron products and services. If I consent, I have the right to withdraw my consent at any time.

Withdraw Consent

You may withdraw your consent to any of the above by notifying a Program representative by: calling 1.877.542.8296; sending a letter to LIBTAYO Surround, PO Box 220262, Charlotte, NC 28211-0262; faxing 1.833.853.8362; or emailing unsubscribe@regeneron.com.

Text Messaging & Calling Consent

I acknowledge that by checking the Text/Call Consent box on page 1, I further authorize Regeneron to contact me by phone or SMS/text message at the telephone number I have provided, to provide me with resources and services related to LIBTAYO or the Program, and to send marketing communications to me. 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 STOP to 59179 from my mobile phone, and that I can get help for text messages by texting HELP 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 THESE COMMUNICATIONS MAY USE PRERECORDED/ARTIFICIAL VOICE MESSAGES AND/OR AN AUTOMATED SYSTEM. I ALSO UNDERSTAND THAT MY CONSENT IS NOT REQUIRED AS A CONDITION OF PURCHASING ANY GOODS OR SERVICES FROM REGENERON OR ITS AFFILIATES.

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

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, including to communicate with me about the LIBTAYO Surround Program and my participation in the LIBTAYO Surround Program, and to evaluate and improve the LIBTAYO Surround Program and associate services provided;
- 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.

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SECTION 10 | Authorization to Disclose/Use Health Information (cont'd)

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.

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

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.