Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

ENROLLMENT/ PRIOR AUTHORIZATION FORM

Fax: 1-888-335-3264
Phone: 1-855-EYLEA4U (1-855-395-3248), Option 4
www.EYLEA4Ueportal.com

EYLEA® (aflibercept) Injection 4 U℠

Reset Form

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

Medicare Beneficiary ID# (Medicare/Medicare Advantage plans only): ☐☐☐☐☐☐☐☐☐☐☐

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

Patient Signature: _____

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

Patient Signature: _____

Section 3.1: Treatment Information/Prescription

Dispense: ☐ Vial(s) NDC: 61755-005-02 ☐ PFS(s) NDC: 61755-005-01
SIG: ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 3 injections followed by 2 mg (0.05 mL) once every 8 weeks
SIG: ☐ Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment
SIG: ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 5 injections followed by 2 mg (0.05 mL) once every 8 weeks
SIG: ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly)

Section 4.1: Prescribing Physician Information

Site of Service: ☐ Physician Office ☐ Hospital Outpatient ☐ Ambulatory Surgical Center Practice/Facility Name: _____
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 National Provider Identifier (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, including e-Portal.

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 hcp.eylea.us

Patient Name

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

Section 5.1: Diagnosis (Select one as a primary diagnosis. For additional diagnoses please indicate on Page 3)

Wet Age-related Macular Degeneration (Wet AMD)

Exudative age-related macular degeneration	Right eye	Left eye	Bilateral	Unspecified eye
With active choroidal neovascularization	☐ H35.3211	☐ H35.3221	☐ H35.3231	☐ H35.3291
With inactive choroidal neovascularization	☐ H35.3212	☐ H35.3222	☐ H35.3232	☐ H35.3292
With inactive scar	☐ H35.3213	☐ H35.3223	☐ H35.3233	☐ H35.3293
Stage unspecified	☐ H35.3210	☐ H35.3220	☐ H35.3230	☐ H35.3290

Macular Edema following Retinal Vein Occlusion (MEfRVO)

Central retinal vein occlusion	Right eye	Left eye	Bilateral	Unspecified eye
With macular edema	☐ H34.8110	☐ H34.8120	☐ H34.8130	☐ H34.8190

Tributary (branch) retinal vein occlusion	Right eye	Left eye	Bilateral	Unspecified eye
With macular edema	☐ H34.8310	☐ H34.8320	☐ H34.8330	☐ H34.8390

Diabetic Macular Edema (DME)

Diabetes mellitus due to underlying condition with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	☐ E08.3211	☐ E08.3212	☐ E08.3213	☐ E08.3219
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E08.3311	☐ E08.3312	☐ E08.3313	☐ E08.3319
Severe nonproliferative diabetic retinopathy with macular edema	☐ E08.3411	☐ E08.3412	☐ E08.3413	☐ E08.3419
Proliferative diabetic retinopathy with macular edema	☐ E08.3511	☐ E08.3512	☐ E08.3513	☐ E08.3519
Unspecified diabetic retinopathy with macular edema	☐ E08.311			

Drug or chemical induced diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	☐ E09.3211	☐ E09.3212	☐ E09.3213	☐ E09.3219
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E09.3311	☐ E09.3312	☐ E09.3313	☐ E09.3319
Severe nonproliferative diabetic retinopathy with macular edema	☐ E09.3411	☐ E09.3412	☐ E09.3413	☐ E09.3419
Proliferative diabetic retinopathy with macular edema	☐ E09.3511	☐ E09.3512	☐ E09.3513	☐ E09.3519
Unspecified diabetic retinopathy with macular edema	☐ E09.311			

Type 1 diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	☐ E10.3211	☐ E10.3212	☐ E10.3213	☐ E10.3219
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E10.3311	☐ E10.3312	☐ E10.3313	☐ E10.3319
Severe nonproliferative diabetic retinopathy with macular edema	☐ E10.3411	☐ E10.3412	☐ E10.3413	☐ E10.3419
Proliferative diabetic retinopathy with macular edema	☐ E10.3511	☐ E10.3512	☐ E10.3513	☐ E10.3519
Unspecified diabetic retinopathy with macular edema	☐ E10.311			

Type 2 diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	☐ E11.3211	☐ E11.3212	☐ E11.3213	☐ E11.3219
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E11.3311	☐ E11.3312	☐ E11.3313	☐ E11.3319
Severe nonproliferative diabetic retinopathy with macular edema	☐ E11.3411	☐ E11.3412	☐ E11.3413	☐ E11.3419
Proliferative diabetic retinopathy with macular edema	☐ E11.3511	☐ E11.3512	☐ E11.3513	☐ E11.3519
Unspecified diabetic retinopathy with macular edema	☐ E11.311			

Other specified diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	☐ E13.3211	☐ E13.3212	☐ E13.3213	☐ E13.3219
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E13.3311	☐ E13.3312	☐ E13.3313	☐ E13.3319
Severe nonproliferative diabetic retinopathy with macular edema	☐ E13.3411	☐ E13.3412	☐ E13.3413	☐ E13.3419
Proliferative diabetic retinopathy with macular edema	☐ E13.3511	☐ E13.3512	☐ E13.3513	☐ E13.3519
Unspecified diabetic retinopathy with macular edema	☐ E13.311			

Patient Name

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

Section 5.1: Diagnosis

Diabetic Retinopathy (DR)

Diabetes mellitus due to underlying condition with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	☐ **E08.3291**	☐ **E08.3292**	☐ **E08.3293**	☐ **E08.3299**
Moderate nonproliferative diabetic retinopathy without macular edema	☐ **E08.3391**	☐ **E08.3392**	☐ **E08.3393**	☐ **E08.3399**
Severe nonproliferative diabetic retinopathy without macular edema	☐ **E08.3491**	☐ **E08.3492**	☐ **E08.3493**	☐ **E08.3499**
Proliferative diabetic retinopathy without macular edema	☐ **E08.3591**	☐ **E08.3592**	☐ **E08.3593**	☐ **E08.3599**
Unspecified diabetic retinopathy without macular edema	☐ **E08.319**			

Drug or chemical induced diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	☐ **E09.3291**	☐ **E09.3292**	☐ **E09.3293**	☐ **E09.3299**
Moderate nonproliferative diabetic retinopathy without macular edema	☐ **E09.3391**	☐ **E09.3392**	☐ **E09.3393**	☐ **E09.3399**
Severe nonproliferative diabetic retinopathy without macular edema	☐ **E09.3491**	☐ **E09.3492**	☐ **E09.3493**	☐ **E09.3499**
Proliferative diabetic retinopathy without macular edema	☐ **E09.3591**	☐ **E09.3592**	☐ **E09.3593**	☐ **E09.3599**
Unspecified diabetic retinopathy without macular edema	☐ **E09.319**			

Type 1 diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	☐ **E10.3291**	☐ **E10.3292**	☐ **E10.3293**	☐ **E10.3299**
Moderate nonproliferative diabetic retinopathy without macular edema	☐ **E10.3391**	☐ **E10.3392**	☐ **E10.3393**	☐ **E10.3399**
Severe nonproliferative diabetic retinopathy without macular edema	☐ **E10.3491**	☐ **E10.3492**	☐ **E10.3493**	☐ **E10.3499**
Proliferative diabetic retinopathy without macular edema	☐ **E10.3591**	☐ **E10.3592**	☐ **E10.3593**	☐ **E10.3599**
Unspecified diabetic retinopathy without macular edema	☐ **E10.319**			

Type 2 diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	☐ **E11.3291**	☐ **E11.3292**	☐ **E11.3293**	☐ **E11.3299**
Moderate nonproliferative diabetic retinopathy without macular edema	☐ **E11.3391**	☐ **E11.3392**	☐ **E11.3393**	☐ **E11.3399**
Severe nonproliferative diabetic retinopathy without macular edema	☐ **E11.3491**	☐ **E11.3492**	☐ **E11.3493**	☐ **E11.3499**
Stable proliferative diabetic retinopathy	☐ **E11.3551**	☐ **E11.3552**	☐ **E11.3553**	☐ **E11.3559**
Proliferative diabetic retinopathy without macular edema	☐ **E11.3591**	☐ **E11.3592**	☐ **E11.3593**	☐ **E11.3599**
Unspecified diabetic retinopathy without macular edema	☐ **E11.319**			

Other specified diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	☐ **E13.3291**	☐ **E13.3292**	☐ **E13.3293**	☐ **E13.3299**
Moderate nonproliferative diabetic retinopathy without macular edema	☐ **E13.3391**	☐ **E13.3392**	☐ **E13.3393**	☐ **E13.3399**
Severe nonproliferative diabetic retinopathy without macular edema	☐ **E13.3491**	☐ **E13.3492**	☐ **E13.3493**	☐ **E13.3499**
Proliferative diabetic retinopathy without macular edema	☐ **E13.3591**	☐ **E13.3592**	☐ **E13.3593**	☐ **E13.3599**
Unspecified diabetic retinopathy without macular edema	☐ **E13.319**			

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

Visual Acuity: Right Eye: _____ / _____
Left Eye: _____ / _____

Has patient started treatment? ☐ Yes ☐ No
Anticipated date of treatment: _____

Secondary and Tertiary Diagnoses

Secondary ☐☐☐.☐☐☐☐

Tertiary ☐☐☐.☐☐☐☐

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 or retain completed and patient-signed form on file at your office if submission is entered via the e-Portal.

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 or retain completed and patient-signed form on file at your office if submission is entered via the e-Portal.