

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

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 8.

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 LYNOZYFIC Surround Program Services

I have read and agree to enroll in LYNOZYFIC Surround program services and to the Patient Certification included in Section 7 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 7 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](https://www.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**, including **Boxed WARNING**, for LYNOZYFIC available at [LYNOZYFIChcp.com](https://www.lynozyfic.com).

Complete pages 1-2 and fax to LYNOZYFIC Surround at 1.833.853.8362 or upload via Docu-Send at [DocuSend.org](https://www.docusend.org)

Patient Name* _____ Date of Birth* _____

Prescriber Name _____ National Provider Identifier (NPI) _____

Request LYNOZYFIC 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 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)

Rx: LYNOZYFIC[®] (linvoseltamab-gcpt) Injection (5 mg or 200 mg)

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

Is patient naïve to LYNOZYFIC therapy? ☐ Yes ☐ No

Step-up dose 1 (5 mg):

SIG: Administer 5 mg as a 4-hour infusion on Week 1, Day 1

Step-up dose 2 (25 mg):

SIG: Administer 25 mg as a 4-hour infusion on Week 2, Day 8

Dispense: 5 5 mg/2.5 mL (2 mg/mL) single-dose vials

☐ Cycles 1-3 (full dose, 200 mg):

SIG: Administer 200 mg as a 4-hour infusion* weekly (at least 5 days apart) for 12 doses

☐ Cycles 4-5 (full dose, 200 mg):

SIG: Administer 200 mg* every other week (2 weeks from the prior weekly dose) for 5 doses

(Cycle information can be found in the Prescribing Information at [LYNOZYFIChcp.com](https://www.lynozyfic.com).)

☐ Biweekly maintenance (full dose, 200 mg)—for continued treatment* with <VGPR:

SIG: Administer 200 mg* every other week

Refills (up to 12 months unless specified): _____

☐ Monthly maintenance (full dose, 200 mg)—for continued treatment* with ≥VGPR and have received at least 17 doses of 200 mg:

SIG: Administer 200 mg* every 4 weeks

Refills (up to 12 months unless specified): _____

*Administer the first 200-mg dose as a 4-hour infusion. If tolerated, infusion time can be reduced to 1 hour for the next dose and then subsequently 30 minutes for all following doses.

*Administer at the infusion duration previously tolerated (for a minimum of 30 minutes).

*Continue treatment until disease progression or unacceptable toxicity.

eRx=electronic prescription; FDA=US Food and Drug Administration; ICD-10-CM= International Classification of Diseases, Tenth Revision, Clinical Modification; VGPR=very good partial response.

SECTION 6 Prescribing 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 LYNOZYFIC 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 LYNOZYFIC Surround program, and I authorize LYNOZYFIC 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 LYNOZYFIC Surround for the patient, including facilitating enrollment into the LYNOZYFIC 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 LYNOZYFIC 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 LYNOZYFIC Surround.

I certify that LYNOZYFIC received free of charge from the LYNOZYFIC 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 LYNOZYFIC Surround PAP terms and conditions. I understand that any free product distributed through the LYNOZYFIC Surround PAP is not contingent on any purchase obligations. I consent to LYNOZYFIC Surround contacting me by fax, mail, or email to provide additional information about LYNOZYFIC or LYNOZYFIC 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 LYNOZYFIC Surround Commercial Copay Program, I hereby represent and warrant that: a) I have verified that the patient does not have coverage for LYNOZYFIC under any state or federally funded healthcare program and has coverage for LYNOZYFIC under a commercial or private insurance plan and is receiving LYNOZYFIC for an FDA-approved indication; b) participation in the LYNOZYFIC 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 LYNOZYFIC 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

Wet signature required; stamped signatures cannot be accepted.*

MM / DD / YYYY

Please see full Prescribing Information, including Boxed WARNING, for LYNOZYFIC available at [LYNOZYFIChcp.com](https://www.lynozyfic.com).

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

SECTION 7

Patient Certifications

Please read the following carefully, then date and sign where indicated in Section 1 on page 1.

I am enrolling in the LYNOZYFIC 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 LYNOZYFIC Surround Commercial Copay Program if confirmed as eligible and understand that any assistance with my applicable cost-sharing or copayment for LYNOZYFIC 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 LYNOZYFIC Surround Commercial Copay Program. I understand that the LYNOZYFIC Surround Commercial Copay Program is not health insurance.

Patients **are not eligible** for the LYNOZYFIC 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 LYNOZYFIC 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 LYNOZYFIC Surround PAP. I (or my legally authorized representative or guardian) am applying for assistance from the LYNOZYFIC 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 LYNOZYFIC Surround PAP, and I agree to inform the LYNOZYFIC Surround PAP team if I am requested to apply to the LYNOZYFIC Surround PAP by my insurance plan, employer, payer, or any other third-party administrator.

Please see full Prescribing Information, including Boxed WARNING, for LYNOZYFIC available at LYNOZYFIChcp.com.

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

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SECTION 7

Patient Certifications (cont'd)

Further, I acknowledge that the LYNOZYFIC 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 LYNOZYFIC Surround PAP for either myself or on behalf of a patient, I authorize the LYNOZYFIC 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 LYNOZYFIC Surround PAP team immediately and understand that I will no longer be eligible for support.

To qualify for the LYNOZYFIC Surround PAP, I understand that I must meet certain income and other eligibility requirements. LYNOZYFIC 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 LYNOZYFIC 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 LYNOZYFIC 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.

Please see full Prescribing Information, including Boxed WARNING, for LYNOZYFIC available at LYNOZYFIChcp.com.

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SECTION 7

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 LYNOZYFIC, 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 LYNOZYFIC Surround Commercial Copay Program, or opt out of the Program entirely at any time by notifying a Program representative by: calling 1.844.746.4363; sending a letter to LYNOZYFIC Surround, PO Box 220262, Charlotte, NC 28222-0262; 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.

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SECTION 7

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 1.844.746.4363; sending a letter to LYNOZYFIC Surround, PO Box 220262, Charlotte, NC 28222-0262; 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 LYNOZYFIC 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 56324 from my mobile phone, and that I can get help for text messages by texting HELP to 56324. 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.

Please see full Prescribing Information, including Boxed WARNING, for LYNOZYFIC available at LYNOZYFIChcp.com.

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SECTION 8

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 LYNOZYFIC, health insurance coverage, claims, prescription, and referral to and enrollment in the LYNOZYFIC 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 LYNOZYFIC Surround reimbursement and coverage assistance program(s), Patient Assistance Programs, and other support programs (together, “LYNOZYFIC Surround Program”);
- For the operation and administration of the LYNOZYFIC Surround Program, including to communicate with me about the LYNOZYFIC Surround Program and my participation in the LYNOZYFIC Surround Program, and to evaluate and improve the LYNOZYFIC Surround Program and associated 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 LYNOZYFIC or the LYNOZYFIC Surround Program.

Please see full Prescribing Information, including Boxed WARNING, for LYNOZYFIC available at LYNOZYFIChcp.com.

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SECTION 8

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

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 LYNOZYFIC 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 LYNOZYFIC Surround at PO Box 220262, Charlotte, NC 28222-0262; 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 LYNOZYFIC 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 **LYNOZYFIC Surround**, please contact us at **1.844.RGN.HEME** (1.844.746.4363), **Option 1**, Monday–Friday, 8 AM–8 PM Eastern time.

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