myRARE® for Evkeeza® (evinacumab-dgnb)

Start Form

Phone: **1-877-EVKEEZA** (1-877-385-3392) **Fax:** **1-844-RAREFAX** (1-844-727-3329) **Upload:** **DocuSend.org**

To prevent delays, complete all fields and **FAX ALL 7 PAGES** to 1-844-RAREFAX (1-844-727-3329) or upload at DocuSend.org. For assistance, call us at **1-877-EVKEEZA** (1-877-385-3392) **Option 1**, Monday–Friday, 9 AM–9 PM Eastern time.

Please make sure to fill out all of the necessary information on pages 1 and 2, which is denoted by REQUIRED.

SECTION 1 Patient Information — REQUIRED

☐ Patient contact information attached

First name _____ Middle initial _____ Last name _____ DOB ____/____/_____ Gender ☐ M ☐ F ☐ Prefer not to disclose

Address _____ City _____ State _____ ZIP _____

Cell phone # (_____)_____ Home phone # (_____)_____

Preferred phone # ☐ Home ☐ Cell OK to leave detailed message? ☐ Yes ☐ No Best time to call _____ ☐ AM ☐ PM

Patient's preferred language (if not English) _____ Email _____

Alternate contact name _____ Alternate contact phone # (_____)_____

Caregiver/legal representative name _____ Caregiver/legal representative phone # (_____)_____

Patient Consents (may also be completed online at www.myRARE.com)

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

I have read and agree to enroll in myRARE® for EVKEEZA and to the Authorization to Disclose/Use Health Information included in **Section 8**

Sign (1 of 2) _____ Date (MM/DD/YYYY) _____

Patient signature/Legal representative

I have read and agree to enroll in myRARE for EVKEEZA and to the Patient Certifications included in **Section 9**

Sign (2 of 2) _____ Date (MM/DD/YYYY) _____

Patient signature/Legal representative

Relationship to patient (if signed by someone other than the patient, please describe your authority to sign on behalf of the patient)

SECTION 2 Patient Insurance Information — REQUIRED

If patient does not have insurance, **you may skip** this section.

Primary Insurance

A copy of insurance card (front and back) is required. Check here if copies are attached ☐

Primary insurance name _____

Primary insurance phone # (_____)_____

Policy # _____

Group # _____

Policyholder name _____

Policyholder's relationship to patient _____

Secondary/Prescription Insurance (if applicable) ☐ Prescription insurance

If copy of insurance card (front and back) is attached, check here ☐

Secondary insurance name _____

Secondary insurance phone # (_____)_____

Policy # _____ BIN # _____

Group # _____ PCN # _____

Policyholder name _____

Policyholder's relationship to patient _____

SECTION 3 Prescribing Physician Information — REQUIRED

Physician Information

Name _____

Practice/Facility name _____

Address _____

City _____ State _____ ZIP _____

Phone # (_____)_____ Fax (_____)_____

National Practice Identifier (NPI) _____ Tax ID # _____-_____

Group NPI _____

Primary Office Contact

(Who myRARE should contact to review patient coverage, collect missing information, and determine treatment setting and product acquisition)

Name _____

Direct phone # (_____)_____

Email _____

Preferred method of contact: ☐ Phone ☐ Email ☐ Fax

Preferred day(s) of contact: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

Infusion Setting and Administration (Benefits will be provided based on indicated preferences and patient's plan coverage)

Preferred Treatment Setting	Preferred Acquisition Channel
☐ Home	Specialty pharmacy with home infusion
☐ Clinical setting ☐ In-office ☐ Infusion center	☐ Buy and bill ☐ Specialty pharmacy to bill

☐ Undecided–Benefits information will be provided for available options based on plan coverage

Name of preferred site of infusion, if different from practice/facility name above

_____

Address _____

City _____ State _____ ZIP _____

Phone # (_____)_____

Complete entire form and **FAX ALL 7 PAGES** to myRARE at 1-844-RAREFAX or upload to **DocuSend.org.**

09/2025 US.EVK.25.08.0003

Please see accompanying full Prescribing Information.

Scan here for myRARE enrollment video

Evkeeza® (evinacumab-dgnb) Injection

myRARE® for Evkeeza® (evinacumab-dgnb)

Start Form

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Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

SECTION 4 Diagnosis/Prescription REQUIRED

REQUIRED ***A confirmed diagnosis of homozygous familial hypercholesterolemia (HoFH) is required for myRARE® Support and EVKEEZA***

☐ I am attesting patient has a confirmed diagnosis of HoFH[1,2]* and I understand EVKEEZA is indicated solely for patients one year and older with homozygous familial hypercholesterolemia. **(ACKNOWLEDGMENT REQUIRED)**

References for HoFH diagnosis: 1. Cuchel M et al. *Eur Heart J*. 2023;44(25):2277-2291. **2.** Gidding SS et al. *Circulation*. 2015;132(22):2167-2192.
*Clinical diagnosis or confirmed through genetic testing: presence of 2 identical (true HoFH) or 2 nonidentical (compound or double HeFH) abnormal LDL-C–raising gene defects.

Rx: EVKEEZA® (evinacumab-dgnb) Injection

Known drug allergies _____

REQUIRED **Patient weight in kg** _____

Dose: 15 mg/kg IV once monthly

Special instructions/Indication: Administer by intravenous infusion over 60 minutes

Infusion fluid type **(please select one)**:

The maximum volume will vary with the patient's body weight

☐ 0.9% Sodium Chloride Injection

OR

☐ 5% Dextrose Injection

Refills _____ Days' supply: 30

If patient has already started treatment, EVKEEZA supply needed for scheduled treatment on (MM/DD/YYYY) _____/_____/_____

SECTION 5 Physician Certification REQUIRED

My signature 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, in my professional judgment, therapy with EVKEEZA 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 myRARE® solely 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 myRARE for the patient including facilitating enrollment into the myRARE 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 myRARE for these purposes. If applicable, I authorize myRARE to conduct a benefits investigation for my patient and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy designated by the patient per their benefit plan provided that, if this prescription is not so designated, myRARE is authorized to transmit this prescription to a network pharmacy it selects. I certify that EVKEEZA received free of charge from the myRARE Patient Assistance Program 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. I understand that any free product distributed through the myRARE Patient Assistance Program is not contingent on any purchase obligations. I consent to myRARE contacting me by fax, mail, or email to provide additional information about EVKEEZA or myRARE. I understand that Regeneron may revise, change, or terminate any program services at any time without notice to me.

Sign _____ **REQUIRED** _____ ☐ Dispense as written ☐ Substitution permitted

Physician signature | Date (MM/DD/YYYY)

SECTION 6 Patient History

At Time of Diagnosis Age at diagnosis _____ Diagnosis: ☐ Clinical **AND/OR** ☐ Genetic

Untreated LDL-C value (prior to any treatment) _____ mg/dL Date_____/_____/_____

Treated LDL-C with standard lipid-lowering therapies (statins and ezetimibe) _____ mg/dL Date_____/_____/_____

☐ Cutaneous or tendinous xanthoma First onset age _____

Family History ☐ Confirmed diagnosis of FH in both parents **OR** ☐ Evidence of FH in both parents

	Maternal	Paternal
Total cholesterol	_____ mg/dL	_____ mg/dL
Untreated cholesterol	_____ mg/dL	_____ mg/dL
Premature ASCVD	☐	☐
Premature cardiac event	☐ _____	☐ _____

Current Status Current/treated LDL-C value _____ mg/dL Date_____/_____/_____ with current treatment(s) indicated below

Previous and/or Current Lipid-Lowering Treatments ☐ Yes (please indicate below)

	Treatment name	Start date	Stop date	Current	Intolerant
☐ Statin		_____/_____/_____	_____/_____/_____	☐	☐
☐ PCSK9i		_____/_____/_____	_____/_____/_____	☐	☐
☐ Zetia® (ezetimibe)		_____/_____/_____	_____/_____/_____	☐	☐
☐ Juxtapid® (lomitapide)		_____/_____/_____	_____/_____/_____	☐	☐
☐ Apheresis		_____/_____/_____	_____/_____/_____	☐	☐
☐ Other		_____/_____/_____	_____/_____/_____	☐	☐

ASCVD=atherosclerotic cardiovascular disease; FH=familial hypercholesterolemia; HeFH=heterozygous familial hypercholesterolemia; LDL-C=low-density lipoprotein-cholesterol.

Complete entire form and **FAX ALL 7 PAGES** to myRARE at 1-844-RAREFAX or upload to **DocuSend.org.**

09/2025 US.EVK.25.08.0003

Please see accompanying full Prescribing Information.

Evkeeza® (evinacumab-dgnb) Injection

Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

SECTION 7 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.

To qualify for the myRARE® Patient Assistance Program, I understand that I must meet certain income and other eligibility requirements. myRARE 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 myRARE 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 myRARE 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. 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.

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

Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

SECTION 8 Authorization to Disclose/Use Health Information (cont'd)

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 EVKEEZA or the myRARE® 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.

I understand that if I refuse to sign this Authorization, I will not be able to participate in the myRARE 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 myRARE at 1107 Nicholas Blvd, Elk Grove Village, IL 60007; fax: 1.844.727.3329; 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 myRARE Program, subject to applicable law, unless I withdraw it earlier. I understand that I may request a copy of this Authorization.

Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

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 myRARE® 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 myRARE Commercial Copay Card Program if confirmed as eligible and understand that any assistance with my applicable cost sharing or copayment for EVKEEZA 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 Commercial Copay Card Program. I understand that the myRARE Commercial Copay Card Program is not health insurance.

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

Further, I acknowledge that the myRARE PAP team may take additional steps to verify my eligibility for the PAP/need-based free drug. Therefore, if I am applying to the myRARE PAP for either myself or on behalf of a patient, I authorize the myRARE 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 myRARE PAP team immediately and understand that I will no longer be eligible for support.

Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

SECTION 9 Patient Certifications (cont'd)

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

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 EVKEEZA, 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 myRARE Commercial Copay Card Program, or opt out of the Program entirely at any time by notifying a Program representative by: calling 1.877.385.3392; sending a letter to myRARE, 1107 Nicholas Blvd, Elk Grove Village; faxing 1.844.727.3329; 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.

Patient name _____ Patient DOB _____/_____/_____

Prescriber name _____ NPI # _____

SECTION 9 | **Patient Certifications (cont'd)**

Withdraw Consent

You may withdraw your consent to any of the above by notifying a Program representative by: calling 1.877.385.3392; sending a letter to myRARE® 1107 Nicholas Blvd, Elk Grove Village, IL 60007; faxing 1.844.727.3329; or emailing unsubscribe@regeneron.com.

Text Message & 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 EVKEEZA 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 776898 from my mobile phone, and that I can get help for text messages by texting HELP to 776898. 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.

Please see accompanying full Prescribing Information.

For any questions or concerns, or to report side effects with a Regeneron product while enrolled in myRARE, please contact us at **1-877-EVKEEZA** (1-877-385-3392) **Option 1**, Monday–Friday, 9 AM–9 PM Eastern time.

REGENERON®

09/2025 US.EVK.25.08.0003

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