EYLEA® (aflibercept) Injection 4U℠

1-855-EYLEA4U, Option 4
(1-855-395-3248)
Fax 1-888-335-3264

Patient Assistance Program—Product Request Form

The EYLEA4U® Patient Assistance Program was designed to help eligible patients who have unmet medical needs, are uninsured, or lack coverage receive EYLEA® (aflibercept) Injection free of charge.
If all fields of this form are not completed in their entirety, shipping delays may occur.

Patient name: _____ **Patient date of birth:** _____/_____/_____

Patient record ID: (If known) R E ☐☐☐☐☐☐

Is the patient still receiving EYLEA?

☐ No, the patient is no longer receiving EYLEA. Please disenroll the patient.

☐ No EYLEA shipment needed at this time.

☐ Yes, the patient continues to receive EYLEA. *Complete sections below.*

☐ **By checking this box, I attest I am not aware of any changes in my patient's insurance coverage (including Medicaid or other state programs) and/or financial status.**

Shipping address:

Account Name: _____ Attn to: _____

Street: _____ City: _____

State: _____ ZIP: _____

Acceptable delivery days: ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

PAP options – please choose ONE option:

☐ **Proactive PAP (upfront)**

EYLEA4U will deliver a PAP-labeled product to practice or site of treatment in advance of the patient's next scheduled date of treatment.

Next anticipated date of treatment: _____

Please return this Product Request Form a minimum of 10 business days prior to the date of treatment to ensure product is delivered prior to the treatment date.

☐ **Reactive PAP (replacement)**

Prescriber treated patient with existing inventory. Requesting replacement for administered product.

	Left eye	*Right eye*
Injection date:		
Administered:	☐ PFS *or* ☐ Vial	☐ PFS *or* ☐ Vial
Lot #:		

PAP = Patient Assistance Program; PFS = pre-filled syringe.

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Patient name: _____ **Patient date of birth:** _____/_____/_____

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☐ **By checking this box, I attest both that product was/will be administered to a PAP-approved patient and the site will not seek reimbursement for product administered for this PAP patient.**

Physician's signature: _____ **Date:** _____

Please fax the completed form to 1-888-335-3264. If you have any questions, please call EYLEA4U at 1-855-EYLEA4U (1-855-395-3248), Option 4, Monday–Friday, 9 AM–8 PM Eastern Time.

This letter contains personal healthcare information from EYLEA4U and should only be viewed by the individual to whom it is addressed. Please contact EYLEA4U at 1-855-EYLEA4U (1-855-395-3248), Option 4, if you have received this letter in error. You may also return this letter to the EYLEA4U Patient Support Program at PO Box 220578, Charlotte, NC 28222-0578.

The EYLEA4U Patient Support Program (EYLEA4U) is committed to protecting the confidentiality of individuals' health and financial information. EYLEA4U receives health information from health care providers, health plans, and health insurers pursuant to written authorizations from patients with prescriptions for EYLEA who have enrolled in EYLEA4U. EYLEA4U program participants also provide EYLEA4U with financial information. EYLEA4U uses patients' health and financial information only to provide coverage and reimbursement, care coordination, and support services and for other purposes required by law or permitted by the EYLEA4U Enrollment Form. EYLEA4U does not share program participants' medical and financial records with Regeneron Pharmaceuticals, Inc.

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