MyPraluent®

MyPRALUENT® Copay Card Program Reimbursement Request

This form is to be used for reimbursement requests of certain product-specific copay, co-insurance or deductible costs directly and actually incurred for a prescription for **PRALUENT® (alirocumab)** under the **MyPRALUENT** Copay Card Program.

Reimbursement is subject to program terms and conditions. Payment of the reimbursement is also subject to verification. Submission of this form is not a guarantee of payment.

PATIENT INFORMATION – please print

First Name _____ Middle _____ Last Name _____
Address 1 _____ Address 2 _____
City _____ State _____ Zip _____
Phone _____ Email _____
Date of Birth _____ Gender ☐ Male ☐ Female

REIMBURSEMENT PROCESS

Please fill out all fields on this form completely and attach the items listed below. Forms submitted without these items will not be eligible for reimbursement. Forms will generally take 7 to 10 business days to process:

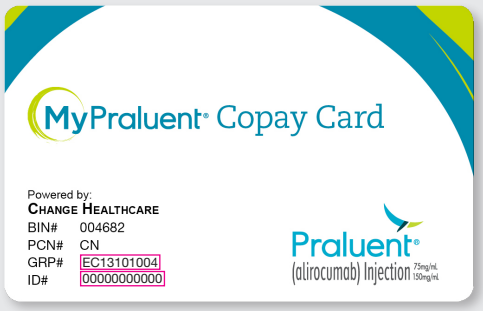
☐ Copy of **PRALUENT** prescription label (prescription receipt from the pharmacy that includes name and address of pharmacy, dosing, and days supply).

☐ Please fill in the following information in the boxes below, or provide a copy of the front of your copay card. See image at right for reference.

Group #: E C ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Member ID: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

☐ Patient signature and certification (see below)



Submit reimbursement request and attachments via mail or fax.
Mail: **MyPRALUENT** Copay Reimbursement Program, 200 Jefferson Park, Whippany, NJ 07981
Fax: **1-908-809-6249**

I, (Insert Name) _____, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the product-specific copay, co-insurance, or deductible expenses requested for reimbursement were actually incurred. My prescription for **PRALUENT** was not paid in whole or in part by Medicare, Medicaid, or any federal or state programs.

Patient Signature _____

If you have questions about the MyPRALUENT Copay Card or you wish to discontinue your participation, please contact us at **1-844-240-3655**, 24 hours a day, 7 days a week.

Praluent® (alirocumab) Injection 75mg/mL 150mg/mL

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