sanofi

SYNVISC APPLICATION

PATIENTConnection®

1. PATIENT INFORMATION

First Name	MI	Last Name	
Address		City	State / Zip Code
Phone #	Date of Birth	Social Security #	
Email Address	Primary Language	Insurance? ☐ Yes ☐ No	
Household size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other:		Annual Household Income: $	
Primary Insurance	Phone #	Secondary Insurance	Phone #
Medical Policy #	Group #	Medical Policy #	Group #
Policyholder Name	DOB	Policyholder Name	DOB

Patient Authorizations

Sanofi Patient Connection does **not** charge any fees for this service; application processing, medication, and shipping are all offered at no cost. Any fees charged to you by a 3rd party completing this application on your behalf are not required by nor remitted to Sanofi.

I have read and agree to the Income Verification included in **Section 5** on page 3.

PATIENT SIGN (REQUIRED)

(1 of 2) **Patient signature/Legal representative if patient is <18 years** Date

I have read and agree to the HIPAA Consent included in **Section 6** on page 3.

PATIENT SIGN (REQUIRED)

(2 of 2) **Patient signature/Legal representative if patient is <18 years** Date

2. DIAGNOSIS AND PRESCRIBING INFORMATION *(See page 2 for code explanations)*

☐ M17.0 ☐ M17.10 ☐ M17.11 ☐ M17.12 ☐ M17.2 ☐ M17.30 ☐ M17.31 ☐ M17.32 ☐ M17.4 ☐ M17.5 ☐ M17.9 ☐ Other:

☐ SYNVISC ONE HYLAN G-F 20 — 8mg/mL — (1) 10mL prefilled syringe	☐ SYNVISC HYLAN G-F 20 — 8mg/mL — (3) 2.25mL prefilled syringes
Inject 1 Synvisc-One syringe into the: ☐ Left knee ☐ Right knee ☐ Bilateral Date needed: Qty kits:	Inject 1 Synvisc Syringe weekly for 3 weeks into the: ☐ Left knee ☐ Right knee ☐ Bilateral Date needed: Qty kits:
Has the patient had any sodium hyaluronate drug treatments in the past? ☐ Yes ☐ No	If yes, last injection date:
If yes, has it been less than 6 months since the last sodium hyaluronate injection for the SAME knee? ☐ Yes ☐ No	Site of last injection: ☐ Left knee ☐ Right knee ☐ Bilateral

3. PRESCRIBER INFORMATION

Prescriber Name	Prescriber Type		State Where Licensed
State License #	NPI #	Tax ID #	DEA #
Treating Physician Name (if different from prescriber)			State Where Licensed
State License #	NPI #	Tax ID #	DEA #
Facility Name		Facility Type: ☐ Physician Office ☐ Hospital Outpatient	
Facility Address*		City / State / Zip Code	
Additional shipping instructions or address, if different from facility address above*			
Primary Contact Name	Title/Role		Primary Phone #
Primary Fax #		Email Address	

**Sanofi product must be shipped to the signing prescriber's office or hospital address authorized by the prescriber and not to a 3rd party.*

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I certify that the Sanofi product is medically necessary for this patient and that I am authorized under State law to prescribe and dispense the requested medication. I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification, medical and insurance information to Sanofi US and/or Sanofi Cares North America and their agents and representatives. I understand that any information provided is for the sole use of the Program to verify my patient's insurance coverage, to assess, if applicable, patient's eligibility for participation in the Patient Assistance Program and to otherwise administer the Sanofi Patient Connection program and related services. I understand that I am under no obligation to prescribe any Sanofi product and that I have not received, nor will I receive, any benefit from Sanofi or their agents or representatives for prescribing a Sanofi product. The facility address noted above in Section 4 is my office or hospital address. My signature certifies that any prescription products received from this Program will be used for the above-named patient only and will not be resold nor offered for sale, trade or barter and will not be returned for credit, nor will payment be sought from any payer, patient or other source for product received from the Program.

HCP SIGN (REQUIRED)

Prescriber Signature (required – no stamps) **Date**

4. RESOURCE CONNECTION *(Note: The patient will receive a separate call from a program associate with contact information for helpful resources checked on the application.)*

Does the patient want the Program to help identify resources provided by other organizations? ☐ Yes (PATIENT SIGNATURE FOR AUTHORIZATION REQUIRED) ☐ No

If yes, please mark which resources the patient may be interested in if available: ☐ Clinical Support Services ☐ Transportation Information ☐ Health Supplies

P: 1.888.847.4877 · F: 1.888.847.1797
P.O. Box 222138 · Charlotte, NC · 28222-2138

SYNVISC APPLICATION

APPLICATION CHECKLIST

☐ Insurance Details (If Applicable)
☐ Diagnosis Code checked
☐ Prescriber signature (REQUIRED)
☐ Patient signature (REQUIRED)

PRODUCT SELECTION

Please click here for full Prescribing Information for Synvisc One.

Please click here for full Prescribing Information for Synvisc.

PATIENT ASSISTANCE CONNECTION ELIGIBILITY REQUIREMENTS

- An application must be submitted for each patient.
- Patient must be a resident of the U.S. or the U.S. territories and be under the care of a licensed healthcare provider authorized to prescribe, dispense, and administer medicine in the U.S.
- Patient must have no insurance coverage or access to the prescribed product or treatment via their insurance.
- Patient must meet the following criteria:
  - Annual household income of ≤400% of the current Federal Poverty Level*
  - If patient may be eligible for Medicaid, they will be required to provide documentation of Medicaid denial before being assessed for patient assistance eligibility

**To assess current Federal Poverty Level details, visit: http://aspe.hhs.gov.*

ADDITIONAL INFORMATION

- A representative from Sanofi may contact you for follow-up on any adverse event you may report regarding a Sanofi product.

ICD-10 CODE EXPLANATIONS

M17.0 (Bilateral primary osteoarthritis of knee)	**M17.31** (Unilateral post-traumatic osteoarthritis, right knee)
M17.10 (Unilateral primary osteoarthritis, unspecified knee)	**M17.32** (Unilateral post-traumatic osteoarthritis, left knee)
M17.11 (Unilateral primary osteoarthritis, right knee)	**M17.4** (Other bilateral secondary osteoarthritis of knee)
M17.12 (Unilateral primary osteoarthritis, left knee)	**M17.5** (Other unilateral secondary osteoarthritis of knee)
M17.2 (Bilateral post-traumatic osteoarthritis of knee)	**M17.9** (Osteoarthritis of knee, unspecified)
M17.30 (Unilateral post-traumatic osteoarthritis, unspecified knee)	

FORM SUBMISSION OPTIONS

U.S. Mail
Sanofi Patient Connection
PO Box 222138
Charlotte, NC 28222-2138

Fax
1.888.847.1797

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5. INCOME VERIFICATION

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

Income Verification: I authorize Sanofi Patient Connection under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that, upon request, SPC 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 SPC 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 further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. If approved for the SPC Patient Assistance Program, I will not seek to have the value of any medication provided to me under this program counted toward my true-out-of-pocket (TrOOP) cost for prescription drugs for my Medicare Part D Plan. Continuation in the SPC Patient Assistance Program is conditioned upon timely verification of income. In addition, I agree to notify SPC if my insurance situation changes.

6. AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION (REQUIRED)

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

HIPAA Consent: I authorize my healthcare providers and staff; my health insurer, health plan or programs that provide me health benefits (together, “Health Insurers”) to disclose to, Sanofi US, its affiliated companies (i.e. Sanofi Pasteur U.S. and Genzyme, a Sanofi Company), Sanofi Cares North America, and authorized third party agents involved in administration of this Program, (collectively “Program Sponsor”), health information about me, including information related to my medical condition, treatment, health insurance coverage, claims, prescriptions and referral to and enrollment in this Program for purposes of determining my participation in, and administering, the Program, which may include contacting me as well as my Doctor/Healthcare Provider, office/hospital staff, insurer (public/private) or others. I understand a representative from Sanofi may contact me for follow-up on any adverse event I may report regarding a Sanofi product. I authorize and consent to release of identifiable information about me including medical, financial and insurance records and information as required for participation in the Program. I understand that identifiable information about me will be kept confidential and will not be further used or disclosed except to administer the Program, or as required by law. I understand that information I authorize to be disclosed may be re-disclosed and is no longer protected by Federal privacy regulations. I agree that this authorization is voluntary and that I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment but I will not be able to participate in this Program. Unless revoked, this authorization shall remain in effect throughout my participation in the Program, including subsequent reapplication as required. I may withdraw this authorization at any time by written notification to my Doctor/Healthcare Provider; however, withdrawal of authorization will terminate my participation in this Program and will not affect information already disclosed under this Authorization.

I understand that it is my responsibility to follow-up with my prescriber or the Program to make sure that my re-orders, as appropriate, are requested in a timely manner by my Provider so I do not run out of medication. I understand that Sanofi US and Sanofi Cares North America reserve the right at any time and without notice to modify or change eligibility criteria or discontinue this Program. I understand that I may withdraw (take back) this Authorization at any time by calling 1.888.847.4877.

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