sanofi

APPLICATION

PATIENT Connection®

Sanofi Patient Connection® is a program (the "Program") to help you get access to the medications and resources you need at no cost. Patient Assistance Connection is part of the Program that provides select Sanofi prescription medications and vaccines, at no cost, if you meet certain eligibility requirements. Patient Assistance Connection is made possible through Sanofi Cares North America.

Regarding use of Authorized Representatives:

While patients are free to authorize family, care team members, or third-party representatives to complete and manage their Sanofi Patient Connection application please be aware that:

- The application can be fully completed by the patient and their licensed healthcare provider (HCP).
- 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 third party completing this application on your behalf are not required by nor remitted to Sanofi.

Who may be eligible for Patient Assistance Connection?

In order to be eligible for this portion of the Program, you must meet the following requirements:

- You must be a resident of the US or the US territories and be under the care of a licensed HCP authorized to prescribe, dispense, and administer medicine in the US.
- You must have an annual household income of ≤400% of the current Federal Poverty Level. If you may be eligible for Medicaid, you will be required to provide documentation of Medicaid denial before being assessed for patient assistance eligibility.
- If you are enrolled in Medicare Part D, you may also be eligible based on the income criteria noted above.
- You must have no insurance coverage or, for commercially insured patients, have no access to the prescribed product or treatment via your insurance.
- For vaccines, you must be 19 years of age or older (except for IMOVAX® Rabies).
- For Thyrogen®, you must be 18 years of age or older.

How do I apply?

To apply for Patient Assistance Connection, all information must be complete and include the following:

Patient Information:

- Complete all relevant information on page 2, and **sign and date** the REQUIRED patient authorizations for HIPAA consent and income verification on page 2.

Healthcare Provider:

- Ask your HCP to complete page 3 and **sign and date** it.
- Ask your HCP to mail or fax your completed application (only pages 2 and 3 are needed).

Missing information may delay processing of your application. **Do not include patient medical records with this application.** Your completed application may be submitted by your HCP as follows:

US Mail
Sanofi Patient Connection
PO Box 222138, Charlotte, NC 28222-2138

Fax
1.888.847.1797

What happens next?

When we receive your application, we will review it to see if you qualify for Patient Assistance Connection. If you are eligible:

1. You and your HCP will receive a letter notifying you of enrollment. If you are a Medicare Part D patient, your plan sponsor will also receive a letter notifying it of your enrollment.
2. You will be enrolled for 12 months. If you are a Medicare Part D patient, you will be enrolled through the end of the calendar year.
3. **Your medication will be sent directly to your HCP's office in approximately 5-7 business days from when you are approved.**

If you do not qualify for Patient Assistance Connection, we will send you and your HCP a letter with the reason for denial.

Note: Sanofi Patient Connection offers patients eligible for patient assistance programs a safe way to dispose of needles through the Sharps program. If you sign up for the Sharps program, you will receive a separate shipment for the Sharps container in order to dispose of your needles.

DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.

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PATIENT TO FILL OUT

Section 1. Patient Information

Patient first name	MI	Last name
SSN		DOB
Address		City
State	Zip	Preferred language (if not English)
Phone number ( )		
Email		
Household size ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other:		Annual household income

I permit Sanofi Patient Connection to speak with the following person and/or organization about the information on this application and the status of my application request.

Patient representative/organization name | Relationship to patient | Phone

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 third party completing this application on your behalf are not required by nor remitted to Sanofi.

I have read and agree to the HIPAA Consent included in **Section 7** on page 4.

PATIENT SIGN (REQUIRED)

(1 of 3) **Patient signature/Legal representative if patient is <18 years** Date

I have read and agree to the Income Verification included in **Section 8** on page 4.

PATIENT SIGN (REQUIRED)

(2 of 3) **Patient signature/Legal representative if patient is <18 years** Date

I have read and agree to the Patient Certifications regarding receiving communications from Sanofi Patient Connection included in **Section 9** on page 5.

PATIENT SIGN (OPTIONAL)

(3 of 3) **Patient signature/Legal representative if patient is <18 years** Date

You must check boxes in **Section 9** and return page 5 with signature to opt in.

Section 2. Insurance Information *(Please provide a copy of the patient's insurance card[s], both front and back, if available)*

Insurance? ☐ Yes ☐ No ☐ If yes, is it Medicare Part D?

Primary insurance name		**Secondary** insurance name	
Insurance phone ( )		Insurance phone ( )	
Policy ID #	Group #	Policy ID #	Group #
Policyholder name (first/last)		Policyholder name (first/last)	
Relationship to patient	DOB	Relationship to patient	DOB

Section 3. Resource Connection

[In order to fill out information below, patient signature is required in Section 1.]

Do you want to participate in the Sharps needle disposal program?

☐ Yes ☐ No

Do you want the Program to help identify resources provided by other organizations?

☐ Yes ☐ No

Please note: You will receive a separate call from a Program associate with contact information for helpful resources checked on your application.

If yes, please mark which resources you may be interested in, if available:

☐ Clinical support services
☐ Nutritional supplements (groceries, food banks, etc)
☐ Transportation information
☐ Home care services (shelter, utilities, etc)
☐ Health supplies
☐ Other (please elaborate):

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PRESCRIBER TO FILL OUT

Please fill out and return this form (prescriber and patient signature required for all applications)

Section 4. Treatment and Prescribing Information *(See Section 6 for supported products)*

Patient name		DOB	
Product #1	☐ Vials ☐ Pens ☐ N/A	Product #2	☐ Vials ☐ Pens ☐ N/A
ICD-10 Code		ICD-10 Code	
Frequency		Frequency	
Maximum dose per day	Qty	Maximum dose per day	Qty

Section 5. Prescriber Information

Prescriber name		State where licensed	
License #	NPI #	Tax ID #	DEA #
Site/facility name		Office contact name	
Type ☐ Clinic ☐ Physician office ☐ Outpatient hospital ☐ Inpatient hospital		Phone ( )	
Facility address*		Fax ( )	
City	State	Zip Code	

**Sanofi product must be shipped to the signing prescriber's office or hospital address authorized by the prescriber and not to a third 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 5 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)	Printed name	Date

Section 6. Products Available With Sanofi Patient Connection

- Adacel® (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine adsorbed)
- Admelog® (insulin lispro injection) 100 Units/mL
- Apidra® (insulin glulisine injection) 100 Units/mL
- Elitek® (rasburicase) IV infusion*[1]
- Imovax® Rabies Vaccine [Human Diploid Cell]
- Insulin Glargine U-300 Injection (1.5 mL or 3.0 mL pens)**
- Jevtana® (cabazitaxel) injection*[1]
- Lantus® (insulin glargine injection) 100 Units/mL
- Lovenox® (enoxaparin sodium injection)*[1]
- MenQuadfi® (Meningococcal [Groups A, C, Y, W] Conjugate Vaccine)
- Mozobil® (plerixafor injection)[1]
- Multaq® (dronedarone) Tablets*
- Pentacel® Diptheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus and Haemophilus b Conjugate (Tetanus Toxoid Conjugate) Vaccine
- Priftin® (rifapentine) Tablets
- Soliqua® 100/33 (insulin glargine & lixisenatide) injection 100 Units/mL and 33 mcg/mL
- Tenivac® (tetanus and diphtheria toxoids adsorbed)
- Thymoglobulin® [Anti-Thymocyte Globulin (Rabbit)]*,[1]
- Thyrogen® (thyrotropin alfa)
- Toujeo® (insulin glargine) Injection 300 Units/mL (1.5 mL or 3.0 mL pens)**

*Please see full US prescribing information, including **Boxed Warning**.
Full U.S. prescribing information for all Sanofi Patient Connection supported products can be accessed at www.sanofipatientconnection.com/medications-available.
**Regular SoloStar® is packaged as 3 pens per pack 450 units/pen; dials up to 80 units per single injection. Max SoloStar® is packaged as 2 pens per pack 900 units/pen; dials up to 160 units per single injection; Max pen dials in 2-unit increments.
[1]If applying for Drug Replacement (Elitek®, Jevtana®, Lovenox®, Mozobil®, and Thymoglobulin®), a copy of the claim, denial, flow sheet(s), and drug dispensing log (with patient name, date of service, product NDC/Lot #, total dosage) must be submitted.

Additional Information

- Sanofi Patient Connection ships most medications in a 90-day supply.
- A representative from Sanofi may contact you for follow-up on any adverse event you may report regarding a Sanofi product.

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Section 7. 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 2.**

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 (ie, 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 healthcare 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.

Section 8. Income Verification (REQUIRED)

***Patient:* Please read the following carefully, then date and sign where indicated in Section 1 on page 2.**

Income Verification: I authorize Sanofi Patient Connection (SPC) 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.

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Section 9. Patient Certification (OPTIONAL)

***Patient:* Please read the following carefully, then date and sign where indicated in Section 1 on page 2.**

PATIENT CHECK (OPTIONAL)

☐ By checking this box, I authorize the Program to collect and use my personal information to contact me by mail, telephone, or email, with information about the Program, disease state, and products, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize the Program to de-identify my health information and use it in performing research, including linkage with other de-identified information the Program receives from other sources, education, business analytics, marketing studies, or for other commercial purposes. I agree that the Program may use my health information for these purposes.

PATIENT CHECK (OPTIONAL)

☐ By checking this box, I authorize the Program to share my personal information with its contracted vendors to contact me by mail, telephone, or email, with information about the Program, disease state, and products, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize the Program to share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services or to send the communications listed above (the "Communications"). I agree that the Program may share my health information with my doctors, specialty pharmacies, and insurers for these purposes.

I understand that I may be contacted by the Program in the event that I report an adverse event associated with a Sanofi product. I understand that I do not have to opt in to receive the Communications, and that I can still receive patient assistance through the Program, as prescribed by my physician. I may opt out of receiving the Communications offered by the Program, at any time by notifying a Program representative by telephone at 1-800-633-1610 or by email via https://cscontactus.sanofi.us/customerInformation.aspx. US residents may opt out or "unsubscribe" from future communications from Sanofi via the following website. For further information regarding privacy rights and how Sanofi uses personal information, please reference our Privacy Policy at https://www.sanofi.com/en/sanofi-us-privacy-policies. I also understand that the Services may be revised, changed, or terminated at any time.

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