SANOFI

MAINE RESIDENTS ONLY

PATIENT Connection™

APPLICATION

MAINE INSULIN SAFETY NET PROGRAM for Sanofi Insulins

Act To Create the Insulin Safety Net Program ("the Act"), effective as of March 1, 2022, mandates that insulin manufacturers create an Insulin Safety Net Program ("the Program") to provide Maine (ME) residents who meet all eligibility criteria with their insulin prescription at no cost. Sanofi is administering the ME Insulin Safety Net Program through Sanofi Patient Connection®, a patient assistance program that helps patients get access to their medications.

What are the eligibility criteria mandated by The Act?

In order to be eligible for this Program, Maine requires you to meet the following requirements:

- You must be a resident of the State of Maine (ME) with a valid Maine identification card that indicates Maine residency in the form of a Maine identification card, driver's license or permit. If the individual is under the age of 18, the individual's parent or legal guardian shall provide proof of residency
- You must not be enrolled in MaineCare.
- You must not be enrolled in prescription drug coverage through an individual or group health plan that limits the total amount of cost-sharing that an enrollee is required to pay for a 30-day supply of insulin, including co-payments, deductibles, or coinsurance to [$75] or less, regardless of the type or amount of insulin needed.
- You must have an annual household income of [≤400%] of the current Federal Poverty Level.
- You must not be eligible to receive health care coverage through a federally funded program or receive prescription drug benefits through the United States Department of Veterans Affairs; and
- If you are enrolled in Medicare Part D, in addition to the criteria above, you must also spend at least [$1,000] on prescription drugs in the current calendar year.

How do I apply?

Complete page 2, sign page 3, then bring or send the form to your healthcare provider to complete and sign page 4. Provide proof of ME residency (copy of ME ID card or driver's license or permit. If you are under 18, your parent or legal guardian needs to provide residency proof. **Missing information may delay processing of your application.** Your completed application should be submitted by your healthcare provider via mail or fax, including your completed application and residency proof to:

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

Fax
1.888.847.1797

What happens next?

Once we receive your application and proof of ME residency:

1. We will notify you within 5 business days if we require additional information to process your application.
2. Once we have all of the required information, we will review it to see if you meet all of ME's eligibility criteria to qualify for the Program within 3 business days.

If you are eligible:

1. You and your healthcare provider will receive a letter within 10 business days notifying you of 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. Your eligibility is renewable upon a redetermination of eligibility.
3. Your medication will be sent directly to your home in approximately 5-7 business days from when you are approved.

If you do not qualify for the Program, we will send you and your healthcare provider a letter within 10 business days with the reason for denial.

Do not include Patient Medical Records with this application.

MAT-US-2109200-v1.0-11/2021

P: 855.937.7765 · F: 1.888.847.1797
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1. PATIENT INFORMATION

First Name	Gender ☐M ☐F	Phone
MI	DOB	Email Address
Last Name	SSN	Primary Language
Address		
City	State ME	Zip Code
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

2. PATIENT INSURANCE INFORMATION

Insurance? ☐Yes ☐No		If yes, is it Medicare Part D? ☐Yes ☐No	
Primary Insurance		Secondary Insurance	
Policy #	Group #	Policy #	Group #
Policyholder Name		Policyholder Name	
DOB		DOB	
Insurance Phone		Insurance Phone	

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3. PATIENT AUTHORIZATION (REQUIRED)

Please read the following carefully, then date and sign where indicated below.

Income Verification: Sanofi Patient Connection and its authorized third party agents will use my date of birth or social security number and/or additional demographic information as needed to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact my credit score. Sanofi Patient Connection and its authorized third party agents reserve the right to ask for additional documents and information at any time.

I state that the information and documents provided in connection with this application are complete and accurate. I agree to immediately inform a Program representative and my Doctor/ Healthcare Provider if my income or insurance status changes during the course of my participation in this Program.

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), 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 reserves the right at any time and without notice to modify or change eligibility criteria or discontinue this Program.

Patient Authorization (REQUIRED)	By signing below, I acknowledge that I have read and agree to the Patient Authorization to Use and Disclose Health Information above.
Patient/Representative Signature (REQUIRED)	
Printed Name	**Date**

4. PATIENT CONSENT

Please read the following carefully, then date and sign where indicated below.

I authorize the Program to contact me by mail, telephone, or e-mail, 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 understand that members of the Program may 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 understand and agree that the Program may use my health information for these purposes and may share my health information with my doctors, specialty pharmacies, and insurers. I understand that I may be contacted by the Program in the event that I report an adverse event. I understand that a representative from Sanofi may contact me for follow-up if 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 Communications offered by the Program, at any time by notifying a Program representative by telephone at 1-800-633-1610 or by mailing a letter to Sanofi US Customer Services, P.O. Box 5925 Mailstop 55A-220A5, Bridgewater, NJ 08807-5925. I also understand that the Services may be revised, changed, or terminated at any time.

Patient Consent	By signing below, I acknowledge that I have read and agree to the Patient Consent above.
Patient/Representative Signature (REQUIRED)	
Printed Name	**Date**

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5. TO BE COMPLETED BY THE HEALTHCARE PROVIDER (HCP)

Please check all that apply

☐ **Patient Assistance** No cost medication Program, prescriber and patient signature required. Check this box if patient does not have insurance coverage.	☐ **Benefits Verification (BV) and Patient Assistance** Insurance coverage research and no cost medication Program, prescriber and patient signature required. Check this box if patient has insurance coverage.

6. TREATMENT AND PRESCRIBING INFORMATION

Patient Name	**DOB**
Concurrent Medications	**Allergies**
Medication #1	**Medication #2**
ICD-10 Code	**ICD-10 Code**
☐ Vials ☐ Pens ☐ N/A	☐ Vials ☐ Pens ☐ N/A
Dosage	Dosage
Sig (e.g., QD)	Sig (e.g., QD)
Days' Supply	Days' Supply
☐ As needed refills for 1 year	☐ As needed refills for 1 year

If required by applicable state-specific law, please attach copies of prescriptions on official state prescription forms.

7. PRESCRIBER INFORMATION

Prescriber Name			State Where Licensed
License #	NPI #	Tax ID #	DEA #
Facility Name			
Facility Address*			
City	State		Zip Code
Collaborating Physician Name			
Office Contact Name		Title/Role	
Primary Phone	Primary Fax		Primary Email

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 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 Program and to otherwise administer the 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 8 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.

Prescriber Signature (REQUIRED – no stamps)	
Printed Name	**Date**

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8. PRODUCT SELECTION

1. Admelog® (insulin lispro injection) 100 Units/mL
2. Apidra® (insulin glulisine injection) 100 Units/mL
3. Lantus® (insulin glargine injection) 100 Units/mL
4. Soliqua® 100/33 (insulin glargine & lixisenatide inj) 100 Units/mL & 33 mcg/mL
5. Toujeo® (insulin glargine injection) 300 units/ml (1.5 ml or 3.0 ml pens)*

*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.

Full U.S. prescribing information for these supported products can be accessed at **www.sanofipatientconnection.com**.

9. WHAT DOES A SUCCESSFUL APPLICATION LOOK LIKE?

To apply for the Program all information must be complete and include the following:

Patient Information:

- Complete all relevant information on page 2, and **sign and date** the Patient Authorization on page 3 (REQUIRED).
- Provide Proof of ME Residency (ME ID card or driver's license or permit). If patient under 18, parent or legal guardian to provide residency proof.

Healthcare Provider:

- Ask your Healthcare Provider (HCP) to complete page 4 and **sign and date** it.
- Ask your HCP to mail or fax your completed application with proof of residency.

Missing information may delay processing of application.

Do not include Patient Medical Records with this application.

10. ADDITIONAL INFORMATION

- Sanofi Patient Connection provides 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.

11. FORM SUBMISSION OPTIONS

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