SANOFI Patient Connection™

P: 1.888.847.4877 F: 1.888.847.1797 · PO Box 222138 · Charlotte · NC · 28222-2138

1. PATIENT INFORMATION

First Name: ____________ MI: ________ Last Name: ____________ Gender: ☐ M ☐ F

Address: ____________ City: ____________ State: ____________ Zip Code: ____________

Phone #: ____________ DOB: ________ SSN: ____________

2. TREATMENT AND PRESCRIBING INFORMATION (SEE INSTRUCTIONS ON PAGE 3 FOR AVAILABLE PRODUCTS) (FOR INSULIN, INDICATE PENS OR VIALS)

Drug: ____________ ICD9/Dx: ________ Rx: ____________ Qty: _____ Refills: _____ BSA/Wt: _____

Drug: ____________ ICD9/Dx: ________ Rx: ____________ Qty: _____ Refills: _____ BSA/Wt: _____

Drug: ____________ ICD9/Dx: ________ Rx: ____________ Qty: _____ Refills: _____ BSA/Wt: _____

3. PRESCRIBER INFORMATION

Prescriber Name: ____________ Prescriber Type: ____________ State License #: ____________

NPI #: ____________ Tax ID #: ____________ DEA #: ____________

Physician Name *(if different from Prescriber)*: ____________ Physician State License#: ____________

Facility Name: ____________ Facility Type: ☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient

Facility Address: ____________ City: ____________ State: ________ Zip Code: ________

Primary Contact Name: ____________ Title/Role: ____________

Primary Phone #: ____________ **Primary Fax #:** ____________ **Primary Contact Email:** ____________

4. REIMBURSEMENT CONNECTION

☐ **Check here for Benefits Verification only** (Prescriber and Patient Signature not required.)

☐ **Check here for Benefits Verification and Patient Assistance Determination if no coverage is found.** (Prescriber and Patient Signatures required.)

Do you have the patient's HIPAA consent on file authorizing the release of the patient's identification and insurance information to Sanofi US and their agents and representatives for benefit verification and Resource Connection purposes?

☐ Yes ☐ No (Confirmation of written patient HIPAA consent is required for benefits verification & Resource Connection services)

Primary Insurance: ____________

Policy #: ____________ Group #: ____________

Policy Holder Name: ____________ DOB: ____________

Insurance Phone #: ____________

Secondary Insurance: ____________

Policy #: ____________ Group #: ____________

Policy Holder Name: ____________ DOB: ____________

Insurance Phone #: ____________

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 I will be supervising the patient's treatments. 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 The Sanofi Foundation for 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. If my patient is applying for patient assistance, I understand that application to the patient assistance program does not guarantee that assistance will be obtained. I understand that Sanofi US and/or The Sanofi Foundation for North America may change or cancel the patient assistance program at any time. I understand that if my patient's financial and/or insurance status changes, the patient's eligibility for the patient assistance program may change, and I agree to immediately notify a Sanofi Patient Connection program representative if I become aware of changes in the patient's insurance status. I agree that Sanofi Patient Connection may contact me for additional information relating to this application either by fax or any other form of communication, including but not limited to e-mail and telephone. 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. I attest that I am not on the HHS/OIG list of Excluded Individuals and that I am authorized under State law to prescribe and dispense the requested medication. 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 payor, patient or other source for product received from the Program. I agree to participate in any recall of the product initiated by the manufacturer.

Sanofi US and The Sanofi Foundation for North America understand your information is private. Any information you provide will only be used by Sanofi Patient Connection, The Sanofi Foundation for North America and parties acting on their behalf to administer the Sanofi Patient Connection program and related services, and to comply with applicable legal requirements.

PRESCRIBER SIGNATURE (REQUIRED - NO STAMPS) **PRINTED NAME** **DATE**

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5. RESOURCE CONNECTION

May the Program contact the patient with information about external resources? ☐ Yes ☐ No If yes, please mark which resources your patient may be interested in if available. If patient speaks a language other than English, please indicate language here: ____

☐ Clinical Support Services ☐ Transportation ☐ Patient Advocacy Support ☐ Other: _________________

☐ Nutritional Supplements (groceries, food banks) ☐ Health Supplies/Cosmetic Aids (wigs, scarves, etc.) ☐ Home Care Services (shelter, utilities)

6. PATIENT ASSISTANCE CONNECTION (CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION)

Total # of people in the household: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **Other:** **Annual Household Income: $**

Please choose one of the following income verification options for your financial eligibility assessment for Patient Assistance Connection. Applications submitted without income documentation may be delayed.

☐ **Option 1: Income Documentation:** Please attach one of the following documents:

- Copy of W-2 or most recently filed U.S. Income Tax Return, (IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040PR), or
- Copy of most recent pay stub plus most recently filed US Income Tax Return, or
- Copy of transcript received through submission of IRS 4506-T (Request for Transcript Form is not accepted) or
- Copy of most recent Social Security/Disability Monthly Check, Award Letter, Benefit Statement or 1099 or
- Copy of Unemployment Determination Letter

☐ **Option 2: Soft Credit Inquiry:** Please access my credit information to estimate my income via a soft credit inquiry. By checking this box and signing below, I authorize Sanofi Patient Connection and its authorized third party contractors to 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.

Patient Name (Please Print): I, ____, state that the information and documents provided in connection with this application are complete and accurate and that I meet all eligibility criteria for participation in the program, including income limits. 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. I understand that application to the Program does not guarantee that assistance will be obtained, and (1) participation in this Program is subject to approval under Program guidelines, (2) approval is for a limited period and (3) periodic re-application is required for continued participation. I understand that my information will be used by the Program sponsor, Sanofi US, its affiliated companies (i.e. Sanofi Pasteur U.S. and Genzyme, a Sanofi Company), The Sanofi Foundation for North America, and authorized third party agents involved in administration of this Program, (collectively "Program Sponsor"), 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 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. My authorization includes release of information relating to treatment for substance abuse, psychiatric and/or medical conditions, and HIV test results or diagnosis, if required. 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 further authorize use of my Social Security number for identification and recordkeeping purposes. I hereby release, for myself and on behalf of my successors and assigns, Program Sponsor (collectively), their officers, directors, employees, and agents from any and all claims or liability arising from their conduct pursuant to this authorization or the use or disclosure of information relating to my Program participation as long as such use or disclosure is made in good faith and without malice and is consistent with this authorization. I understand that Sanofi US and The Sanofi Foundation for North America reserve the right at any time and without notice to modify or change eligibility criteria, or modify or discontinue this Program.

SIGNATURE OF PATIENT **PATIENT SOCIAL SECURITY NUMBER** **DATE OF BIRTH** **DATE**

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.

Representative/Organization Name: _____________________________ Relationship:______________________ Phone Number:__________________

Sanofi US, The Sanofi Foundation for North America, and/or its agents reserve the right in their sole discretion to modify or terminate any and all components of Sanofi Patient Connection at any time.

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PRODUCT SELECTION (PLEASE ENTER DESIRED PRODUCT IN SECTION 2 FOR ALL SERVICES)

- Adacel® (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine absorbed)
- Apidra® (insulin glulisine [rDNA origin] injection)
- Auvi-Q™ epinephrine injection, USP
- Clolar® (clofarabine) Injection
- Eligard® (leuprolide acetate) Suspension
- Elitek® (rasburicase)
- Imogam® Rabies-HT Immune Globulin, [Human] USP, Heat Treated
- Imovax® Rabies Vaccine [Human Diploid Cell]
- Jevtana® (cabazitaxel) Injection
- Lantus® (insulin glargine [rDNA origin] injection)
- Leukine® (sargramostim)
- Lovenox® (enoxaparin sodium injection)
- Menactra® Meningococcal (Groups A, C, Y and W-135) Polysaccharide Diphtheria Toxoid Conjugate Vaccine
- Menomune® (Meningococcal Polysaccharide Vaccines Groups A, C, Y and W-135 combined)
- Mozobil® (plerixafor injection)
- Multaq® (dronedarone) Tablets
- Priftin® (rifapentine) Tablets
- Tenivac® (tetanus and diphtheria toxoids adsorbed)
- TheraCys® (BCG Live[Intravesical])
- Thymoglobulin® [Anti-thymocyte Globulin (Rabbit)]
- Zaltrap® (ziv-aflibercept)

INSTRUCTIONS FOR REIMBURSEMENT CONNECTION AND RESOURCE CONNECTION

- Please complete all fields in Sections 1- 4 for Reimbursement Connection services and Sections 1, 3 and 5 for Resource Connection services.
- Sanofi Patient Connection does not require income documentation, household size information or patient signature for Reimbursement and Resource Connection services.
- In Section 4, the licensed Prescriber must indicate if there is a patient consent on file. Prescriber signature is not required for benefit verification only.
- If the "Yes" box is checked in Section 5, our team will contact you or your patient to help identify resources provided by other organizations.

INSTRUCTIONS FOR PATIENT ASSISTANCE CONNECTION

Program Eligibility

- An application must be submitted for each patient.
- Patient must be a US citizen or resident.
- Patient must have no insurance coverage or be functionally uninsured.
- Patient must be under the care of a licensed healthcare provider who is authorized to prescribe, dispense, and administer medicine in the US. SL# is required.
- Patient must meet the following financial criteria:
  - Annual household income of ≤500% of current Federal Poverty Level (FPL) for oncology/hematology products;
  - Annual household income of ≤250% FPL for all other products.
- For Vaccines, patient must be 19 years of age or older (except IMOVAX RABIES and IMOGAM RABIES HT).
- Sections 1-6 must be completed to avoid delays. Incomplete forms will not be processed until missing information is received.

Documentation Requirements

- Please complete Sections 1-6.
- If applying for Drug Replacement, please submit a copy of the claim, denial, flow sheet(s) and drug dispensing log (with patient name, product NDC/Lot #, dates of service & total dosage.
- Please have the patient sign the bottom of Section 6 for Patient Assistance Connection assistance.
- Proof of income is required:

  Option 1) Submit an acceptable form of income documentation:
  - Copy of W-2 or most recently filed U.S. Income Tax Return (IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040PR), **or**
  - Copy of most recent pay stub **plus** most recently filed US Income Tax Return, **or**
  - Copy of transcript received through submission of IRS 4506-T (request for transcript form is not accepted) **or**
  - Copy of most recent Social Security/Disability Monthly Check, Award Letter, Benefit Statement or 1099 **or**
  - Copy of Unemployment Determination Letter

  Option 2) Give permission to program to access patient credit information to estimate income via a soft credit inquiry.

10. FORM SUBMISSION OPTIONS

SECURE PROVIDER PORTAL	FAX	U.S. MAIL
www.visitspconline.com	1.888.847.1797	Sanofi Patient Connection P.O. Box 222138 Charlotte, NC 28222-2138

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