ENROLLMENT FORM

Sanofi Patient Services

ALPROLIX® [Coagulation Factor IX (Recombinant), Fc Fusion Protein]

ALTUVIIIO® Antihemophilic Factor (Recombinant), Fc-VWF-XTEN Fusion Protein-ehtl

ELOCTATE® [Antihemophilic Factor (Recombinant), Fc Fusion Protein]

Complete entire form and **fax** to **855-398-7634**

For support **call 855-749-4363** M-F, 8am-8pm ET

TREATMENT SELECTION ☐ ALPROLIX ☐ ALTUVIIIO ☐ ELOCTATE

REQUESTED SERVICES ☐ Insurance Investigation ☐ Free Trial Plus ☐ Factor Access ☐ Copay
☐ Communications and outreach from a Sanofi Community Relations Member

1. PATIENT INFORMATION

First Name _____ MI _____

Last Name _____

DOB ____/____/____ Gender ☐ M ☐ F ☐ Other

Address _____

City _____ State _____ Zip _____

Email _____

Cell (_____) _____ Other (_____) _____

☐ Voicemail ☐ Text

Primary language (if not English) _____

Caregiver (if applicable) _____

Caregiver Phone (_____) _____

2. PRESCRIPTION INFORMATION & PRESCRIBER CERTIFICATIONS

ICD-10 Code _____

Previous medication(s) (most recent first) _____

_____

_____

Known medication allergies _____

_____

Date of first infusion ____/____/____

Weight _____ ☐ kg / ☐ lb Date recorded ____/____/____

Ancillary Supplies ☐ Yes ☐ No

Intravenous Access

☐ Peripheral supplies kit, Quantity Sufficient (QS), Use as directed (UAD)

☐ Port supplies kit, Quantity Sufficient (QS), Use as directed (UAD)

A. PRESCRIPTION REQUIRED FOR PATIENT SERVICES TO SEND PRESCRIPTION TO THE **SPECIALTY PHARMACY AND/OR FACTOR ACCESS**

Medication	Purpose	Dose / Frequency / Instructions	No. of Doses / Quantity	No. of Refills
☐ ALPROLIX IV ☐ ALTUVIIIO IV ☐ ELOCTATE IV	☐ Prophylaxis			Prophylaxis _____
	☐ On-Demand			Bleed Dose _____
	☐ Minor Bleed			
	☐ Major Bleed			

B. PRESCRIPTION REQUIRED IF APPLYING FOR **FREE TRIAL PLUS** (Only filled by the Sanofi Free Goods Pharmacy)

Medication	Purpose	Dose / Frequency / Instructions	No. of Doses / Quantity	No. of Refills
☐ ALPROLIX IV ☐ ALTUVIIIO IV ☐ ELOCTATE IV	☐ Prophylaxis			Prophylaxis 0
	☐ On-Demand			Bleed Dose 0
	☐ Minor Bleed			
	☐ Major Bleed			

My signature certifies that the person named on this form is my patient; that the information provided on this application, to the best of my knowledge, is complete and accurate; and that therapy with ALPROLIX/ALTUVIIIO/ELOCTATE is medically necessary.

I acknowledge that I have obtained authorization to release the patient's personal health information and the information on this form and any prescription to Genzyme Corporation (together with its parents and affiliates, "Sanofi") and its third-party business partners, vendors, and other agents ("Agents") for the purpose of providing product support services ("the Programs") including conducting a benefits investigation. I further certify that any service provided by Sanofi on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use any Sanofi product or service for anyone, and my decision to prescribe ALPROLIX/ALTUVIIIO/ELOCTATE was based solely on my determination of medical necessity. I understand that my information may be used by Sanofi to manage and improve the Programs, to communicate with me about my experience with the Programs, and/or to send patient materials relating to the Programs. With respect to any free product provided to the patient listed above, I understand that provision of the product is not contingent on any purchase obligations. I also understand that no claim for reimbursement will be submitted to Medicare, Medicaid, or any third-party payer for medication received free of charge under the Program, or for related medical procedures and services; nor should the free product be sold, traded, or distributed for sale. I authorize Sanofi or its affiliated companies or subcontractors, including in-network specialty pharmacies, through the Sanofi Patient Services Program ("Program") to forward this prescription electronically, by facsimile, or by mail to the relevant in-network pharmacy for the abovenamed patient. In addition, I certify and warrant the following: This request has been prepared exclusively by me or my office. I understand that Sanofi Patient Services may revise, change, or terminate any program services at any time without notice to me. I will notify the Specialty Pharmacy immediately if ALPROLIX/ALTUVIIIO/ELOCTATE is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. I authorize Sanofi as my designated agent and on behalf of my patient to (1) forward the above service request form and furnish any information on this form to the insurer of the above-named patient and (2) forward the above prescription, by fax or other modes of delivery, to dispensing pharmacy. I agree to assist in efforts to secure access to ALPROLIX/ALTUVIIIO/ELOCTATE for my patient in the event of a coverage delay. **The prescriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.**

OPTIONAL – ☐ TEXT MESSAGING: By providing your patient's email address or cell phone number, and checking this box, you certify that you have obtained the patient's consent to receive email and/or text messages (as applicable) related to enrolling into the Sanofi Patient Services Program, including notifying the patient that they have the right to opt out of future messages at any time, and, in the case of text messages, that their wireless service provider's message/data rates may apply and their consent is not required as a condition of purchasing any goods or services from Sanofi US or their affiliates.

DISPENSE AS WRITTEN / DO NOT SUBSTITUTE

SIGN & DATE / /

PRESCRIBER SIGNATURE **DATE**

SUBSTITUTION PERMISSIBLE

SIGN & DATE / /

PRESCRIBER SIGNATURE **DATE**

CA, MA, NC & PR: interchange is mandated unless prescriber writes the words "NO SUBSTITUTION." _____

ATTN: New York and Iowa providers, please submit electronic prescription.

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3. PREFERRED SPECIALTY PHARMACY

Prescription to be sent to Specialty Pharmacy by ☐ Healthcare Provider ☐ Patient Services

Ship to ☐ Patient's home ☐ Prescriber's office

Indicate preferred Specialty Pharmacy

Name _____ Phone (_____) _____ Fax (_____) _____

4. INSURANCE INFORMATION

☐ PATIENT HAS NO INSURANCE

DISREGARD OR SKIP THIS SECTION IF ATTACHING COPIES (FRONT AND BACK) OF ALL AVAILABLE INSURANCE AND PRESCRIPTION CARDS

Primary Health Insurance _____

Insurance Phone _____

Policy ID # _____

Group # _____

Policyholder Name (First/Last) _____

Employer of Policyholder _____

Relationship To Patient _____

Secondary Health Insurance _____

Insurance Phone _____

Policy ID # _____

Group # _____

Policyholder Name (First/Last) _____

Prescription Drug Insurance (if different) _____

Insurance Phone _____

Policy ID # _____

Group # _____

RxBIN # _____

RxPCN # _____

5. PRESCRIBER INFORMATION

REQUIRED – SPECIALTY PHARMACY WILL NEED TO CONTACT THE PROVIDER PRIOR TO DISPENSING

Prescriber Name _____

Prescriber Facility Name _____

Office Contact Name _____

Specialty _____

Office Contact Email _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Fax (_____) _____

NPI _____ Tax ID _____

State License _____

6. AUTHORIZATION FOR RELEASE AND USE OF HEALTH INFORMATION

PATIENT – PLEASE READ THE FOLLOWING CAREFULLY, THEN DATE AND SIGN WHERE INDICATED.

By signing this Authorization to Release Health Information ("Authorization"), I authorize my health care providers (including my pharmacies), and my health plans and insurers [and their contractors] (collectively, the "Parties") to disclose to Genzyme Corporation including its parents, affiliates, and its third party business partners, vendors, and other agents (collectively, "Sanofi") information about my disease, treatment, insurance coverage, and payment for my therapy (together with the information I have provided on this Enrollment Form and may provide in the future, "my Information") for the purposes of Sanofi providing me with patient support services and sending me communications that I have agreed to receive elsewhere in this Enrollment Form.

The Parties and Sanofi may use and disclose my Information for the purposes of providing certain support services I agree to in this Enrollment Form, including, but not limited to: (1) determining if I am eligible to participate in the Sanofi Patient Services Program ("the Program"); (2) to manage and improve the Program; (3) to communicate with me about my experience with the Program; (4) to send materials relating to the Program; (5) investigating my health insurance coverage; (6) operating and administering the Program; and (7) contacting me for follow-up on any adverse event I may disclose regarding a Sanofi product. I further authorize Sanofi to de-identify my health information and use it in performing research, education, business analytics, and marketing studies, or for other commercial purposes, including linkage with other de-identified information Sanofi may receive from other sources.

I understand that once my information has been disclosed to Sanofi, federal privacy laws may no longer protect the information from further disclosure, but that Sanofi intends to use and disclose my information only in accordance with this Authorization or as otherwise allowed by law. I understand that Sanofi may provide my Specialty Pharmacy with payment to obtain, use or disclose my information. I understand that my personal health information may be used for communications between Sanofi and me which may be considered marketing. Specialty Pharmacies may receive remuneration in exchange for disclosing my information and/or for providing me with support services in connection with the Sanofi Patient Services Program. You may have certain rights under applicable data privacy laws regarding your personal information, including the right to access your personal information held by Sanofi. For further information regarding these rights, please reference our Global Privacy Policy at www.sanofi.com/en/privacy-and-data-protection. Withdrawal of this Authorization will end further reliance on this Authorization (and my participation in the Program) but it will not affect any use or disclosure of my Information before my notice of withdrawal is received and processed.

I understand that I may refuse to sign this Authorization and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits, including access to therapy. Authorization expires 5 years from the date I signed unless subject to applicable law unless or until I withdraw (take back) this Authorization before then. I understand that I may withdraw this Authorization at any time by sending a written notice that includes my name, address, and phone number, to Sanofi, ATTN: RBD Patient Services, 450 Water St, Cambridge, MA 02141, or by emailing RBDPatientSolutions@sanofi.com.

REQUIRED – By signing below, I certify that I have read and understand the Authorization to Release Health Information and agree to its terms. I understand that I am entitled to a copy of this Authorization upon request.

SIGN & DATE ____ / ____ / ____

PATIENT / LEGAL REPRESENTATIVE SIGNATURE (1 OF 2) **DATE**

Printed name if signed by legal representative

Relationship to patient

7. PATIENT CERTIFICATIONS

PATIENT – PLEASE READ THE FOLLOWING CAREFULLY, THEN DATE AND SIGN WHERE INDICATED.

I attest that I have a valid prescription for ALPROLIX/ALTUVIIIO/ELOCTATE, that I reside in the US or a US territory, and that I am being treated by a prescriber in the US or a US territory. If enrolling in the Copay Program, I attest that I have commercial insurance, and I further attest that I will not use a state or federally-funded health insurance program such as Medicare (including Medicare Part D), Medicaid, Medigap, VA, DoD, TRICARE®, or similar federal or state pharmaceutical assistance programs to pay in part or in full for my ALPROLIX/ALTUVIIIO/ELOCTATE prescription.

I authorize Sanofi to provide me with various therapy support services for which I am eligible, which may include but are not limited to:

- Patient education and adherence support
- Insurance benefits investigation to assess eligibility for coverage and reimbursement (if requested)
- Coverage and financial assistance support (if requested)
- Other support services that may be added in the future, as well as any information or materials related to such support services

I acknowledge and understand that Sanofi cannot provide me with medical advice, and I will direct all treatment-related questions to my healthcare professional.

CONTINUED ON PAGE 4

7. PATIENT CERTIFICATIONS (CONTINUED)

I understand and agree that Sanofi may contact me about such services and information by mail, e-mail, telephone call, fax, or other means at the telephone numbers, email, and mailing addresses I provide. I understand a representative from Sanofi may contact me for follow-up on any adverse event I may report regarding a Sanofi product. I understand that I do not have to enroll in the Program and that if I choose not to enroll, I can still receive my medication as prescribed by my physician. I may opt out of the Program at any time by calling the Case Management team at 833.723.5463, emailing RBDPatientSolutions@sanofi.com, or sending a written notice that includes my name, address, and phone number, to Sanofi, ATTN: RBD Patient Services, 450 Water St, Cambridge, MA 02140. Sanofi reserves the right to modify or terminate any or all support services at any time without notice.

If enrolling in the Sanofi Copay Program* (the "Copay Program"), I understand that my Copay Card information will be sent to my designated Specialty Pharmacy along with my prescription, and any assistance with my applicable cost-sharing or copayment for ALPROLIX/ALTUVIIIO/ELOCTATE will be made in accordance with the Copay Program terms and conditions.

***Not valid if the patient is utilizing a state or federally-funded health insurance program such as Medicare (including Medicare Part D), Medicaid, Medigap, VA, DoD, TRICARE®, state pharmaceutical assistance program, etc. to pay in part or in full for your ALPROLIX/ALTUVIIIO/ELOCTATE prescription.

I also agree that Sanofi may verify my eligibility for the Sanofi Patient Services Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional financial, insurance, and/or medical information. I authorize Sanofi 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, Sanofi 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 Sanofi 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 Sanofi Patient Services 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 Sanofi Patient Services 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 Sanofi Patient Services Program is conditioned upon timely verification of income. In addition, I agree to notify Sanofi RBD Patient Services immediately if my insurance status or my income changes. Sanofi reserves the right to review assistance requests based on patient needs and to change program guidelines or terminate the program at any time without notification.

COMMUNICATIONS AND OUTREACH FROM A SANOFI COMMUNITY RELATIONS MEMBER

I agree that Sanofi and its agents (such as third-party business partners) can contact me by mail, email, fax and/or telephone, including calls and text messages (if consent is provided to receive text messages), and send me information about rare blood disorders and relevant Sanofi products, promotions, services, and research studies, ask my opinion about such information and topics, including through market research and disease-related surveys, and share the information I provide with one another to perform these activities, and to de-identify it for use in performing research, education, business analytics, marketing studies, and other commercial purposes. If I agree to receive text messages, I understand that text messaging rates may apply. Your information will not be sold to any third party but may be provided to regulatory authorities if required. You may have certain rights under applicable data privacy laws regarding your personal information, including the right to access your personal information held by Sanofi. For further information regarding these rights, please reference our Global Privacy Policy. You may opt out of continued receipt of such communications at any time by e-mailing RBDPatientSolutions@sanofi.com. Receipt of these communications is not required to receive Sanofi patient support services.

TEXT MESSAGING CONSENT

I acknowledge that by checking the text message consent box below, I expressly consent to receive text messages or automated calls from or on behalf of Sanofi at the mobile phone number(s) that I provide.

I confirm that I am the subscriber for the mobile phone number(s) provided, and I agree to notify Sanofi promptly if any of my number(s) change in the future. I understand that my wireless service provider's message and data rates may apply to any text messages that I receive from or on behalf of Sanofi at the mobile phone number(s) that I provide. I understand that I can opt out of future text messages at any time. To opt out of receiving texts, I understand that I should reply "STOP" to 617-915-4365.

I understand that my consent to receiving text messages from or on behalf of Sanofi is not required as a condition of purchasing any goods or services from Sanofi or its affiliates.

OPTIONAL – ☐ Check this box to agree to receive text messages.

REQUIRED – By signing below, I certify that I have read and understand the Sanofi Patient Services Program Authorization and agree to its terms

SIGN & DATE _____ / /

PATIENT / LEGAL REPRESENTATIVE SIGNATURE (2 OF 2) **DATE**

_____
Printed name if signed by legal representative

_____
Relationship to patient