SANOFI GENZYME SUPPORT PROGRAMS

MyELOCTATE: 1-855-693-5628 MyALPROLIX: 1-855-692-5776

FREE TRIAL PLUS*

Receive your first 30-day supply of therapy immediately with a valid prescription from your healthcare provider. You may also be able to receive free factor for up to 1 year, if needed.

COPAY ASSISTANCE*

Sanofi Genzyme offers a copay program to eligible patients that can cover up to $20,000 of out-of-pocket copayment or co-insurance costs associated with your prescription.

FACTOR ACCESS*

Helps you access ELOCTATE or ALPROLIX, even if your insurance coverage is interrupted— for example, you are in between jobs or changing insurers.

*Those with federal and state government insurance, such as Medicare, Medicaid, or TRICARE® are not eligible. Other eligibility requirements may apply. Sanofi Genzyme reserves the right to modify or discontinue the programs at any time. Please visit Eloctate.com or Alprolix.com for more information.

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

Sanofi Genzyme support program: ☐ Free Trial Plus ☐ Copay ☐ Factor Access ☐ Benefits Investigation **Prescription:** ☐ ELOCTATE or ☐ ALPROLIX

PRESCRIBER INFORMATION (required)

Prescriber name: _____ State license #: _____ NPI #: _____

Facility name: _____ Facility address: _____

City: _____ State: _____ ZIP: _____ Tax ID #: _____

Office contact: _____ Phone: _____ Fax: _____ Email: _____

Ship to: ☐ Patient home ☐ Prescriber's office

PRESCRIPTION INFORMATION (complete if applying for Free 30-Day Trial or Factor Access)

Patient Name: _____ DOB: ___/___/___ Dose: _____

Directions: _____

Patient Weight: _____ kg _____ lbs # of Refills: _____ _____

PRESCRIBER AUTHORIZATION FOR FREE 30-DAY TRIAL OR FACTOR ACCESS (required)

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 Sanofi Genzyme, its affiliates, and their representatives, agents, and contractors, for the purpose of providing product support services. I further certify that any service provided by Sanofi Genzyme 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 Genzyme product or service for anyone, that my decision to prescribe a Sanofi Genzyme product was based solely on my determination of medical necessity, and that I will not seek reimbursement for any medication or service provided by or through Sanofi Genzyme from any government program or third-party insurer. I will notify Sanofi Genzyme immediately if the Sanofi Genzyme product is no longer medically necessary for this patient's treatment or if my patient's insurance status changes.

I authorize Sanofi Genzyme 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 mode of delivery, to the pharmacy chosen by the above-named patient.

I certify the rationale for prescribing ALPROLIX [ICD-10 D67] or ELOCTATE [ICD-10 D66] and I will be supervising the patient's treatment accordingly.

PRESCRIBER SIGNATURE (dispense as written) _____ DATE: _____

PRESCRIBER SIGNATURE (substitution permitted) _____ DATE: _____

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

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

Code for Sanofi Genzyme internal use only

Print and fax completed enrollment forms to 1-855-398-7634

My ELOCTATE: 1-855-693-5628
My ALPROLIX: 1-855-692-5776

INSTRUCTIONS FOR PATIENTS

PATIENT INFORMATION (required)

Patient name: _____ DOB: ___/___/___ SSN (last 4 digits only): __ __ __ __ Sex: M ☐ F ☐

Parent/guardian name: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ _____☐OK to leave message Email: _____

Language preference: ☐English ☐Spanish ☐Other

Current therapy: _____ Current weight: _____

Have you ever been on ELOCTATE or ALPROLIX? ☐Yes ☐No

Required for Factor Access program only

1. Have you applied for Medicaid? (If you said yes, you must include your Medicaid denial letter. Letter must be within the last 90 days) ☐Yes ☐No
2. Adjusted gross income (gross income from taxable sources minus allowable deductions, such as unreimbursed business expenses, medical expenses, alimony, and deductible retirement plan contributions). _____
3. Verification of income is required for participation in the Factor Access Program. Acceptable documentation includes a W-2, IRS-1040, or a recent paystub.

PATIENT INSURANCE INFORMATION (required)

☐Check if patient does not have insurance

Primary insurance name: _____

Insurance phone: _____

Policy #: _____ Group #: _____

Policy holder name: _____

Policy holder DOB: ___ /___ /___

Employer of Policy holder: _____

Subscriber's relationship _____

Secondary insurance name: _____

Insurance phone: _____

Policy #: _____ Group #: _____

Policy holder name: _____

Policy holder DOB: ___ /___ /___

Y	N	PATIENT VERIFICATION QUESTIONS
☐	☐	Do you have a valid prescription for ALPROLIX or ELOCTATE?
☐	☐	Do you have commercial insurance?
☐	☐	Are you enrolled in any state or federally funded health insurance program such as Medicare (including Medicare Part D), Medicaid, Medigap, VA, DOD, TRICARE®, etc?
☐	☐	Are you a current resident of the United States or US Territory, or visa holder?
☐	☐	Are you being treated by a prescriber in the United States or US Territory?

Pharmacy Benefit Manager (PBM): _____ Group #: _____

Policy #: _____ Rx BIN #: _____ Rx PCN #: _____

Current specialty pharmacy: _____ Phone number: _____

Specialty pharmacy address: _____

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READ AND SIGN AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (required)

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy or other institutional healthcare providers to disclose to Genzyme Corporation, and companies working with Genzyme Corporation (collectively, "Sanofi Genzyme"), health information relating to my medical condition, treatment, and insurance coverage that is needed to provide me with product support including but not limited to online support, and financial and reimbursement services. I also authorize the disclosure of my health information to the specific individuals I have designated below. Once my health information has been disclosed to Sanofi Genzyme and/or such other individuals, I understand that federal privacy laws may no longer protect the information. However, Sanofi Genzyme agrees to undertake reasonable efforts to maintain my Personal Health Information in a secure manner and not to disclose it to third parties without a legitimate reason for doing so or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Sanofi Genzyme in exchange for the health information and/or for any therapy support services provided to me.

I may cancel this Authorization at any time by mailing a letter to: Sanofi Genzyme, Attn: Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142 or visiting Sanofi Genzyme.com/privacy. Canceling this Authorization will end my consent to further disclosure of my health information to Sanofi Genzyme, and my receipt from Sanofi Genzyme of therapy support services, after the date Sanofi Genzyme receives my letter, but will not affect my healthcare providers' or Sanofi Genzyme's ability to use and disclose health information that it has already disclosed or received before receipt of my letter. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires ten (10) years from the day it is given as indicated by the date below, unless canceled as set forth above. I understand I may receive a copy of the signed authorization if requested. I understand that I may refuse to sign this authorization and that it is strictly voluntary. I further understand that my treatment (including with a Sanofi Genzyme product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization.

PRINT NAME: _____

PATIENT SIGNATURE (required): _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required for patients under 18 years old): _____ Date: _____

(optional) In addition, I authorize the disclosure of my health information to the following designated individual:

Designated individual (print name) _____ Relationship: _____

PATIENT SERVICES AUTHORIZATION

I further authorize Sanofi Genzyme to provide me with various therapy support services for which I am eligible, including but not limited to: online support, financial assistance services, reimbursement services, and compliance and persistency services, as well as any information or materials related to such services. I also authorize Sanofi Genzyme to contact me to ask me about my experience with or thoughts about products, services, and programs that Sanofi Genzyme offers or sponsors. I understand and agree that any information I provide may be used by Sanofi Genzyme to help develop new products, services, and programs. I understand and agree that Sanofi Genzyme may contact me about such services and information by mail, e-mail, telephone call, fax, or text message (including autodialed or prerecorded calls), or other means at the telephone numbers, e-mail, and mailing addresses I provide. I also authorize Sanofi Genzyme to use my health information in connection with the services, including, without limitation, sharing such information with my healthcare provider, insurance provider, or pharmacy.

PATIENT SIGNATURE (required): _____ Date: _____

PARENT / GUARDIAN SIGNATURE (required for patients under 18 years old): _____ Date: _____

AGREE TO RECEIVE RELEVANT SANOFI GENZYME MARKETING COMMUNICATIONS

Sanofi Genzyme would like to send you additional information about our products and financial assistance programs.

You must be thirteen (13) years or older to enroll. If you are aged 13 to 18, you must get your parent's or guardian's permission before providing your personal health information. We will not sell or transfer your Personal Data to any unrelated third party for marketing purposes without your express permission. We may also share such Personal Data with regulatory authorities, if required, or contact you to conduct market research.

I authorize Sanofi Genzyme, and companies working with Sanofi Genzyme, to contact me by mail, e-mail, fax, and/or telephone, including calls and text messages made using an automatic telephone dialing system or a prerecorded voice at the telephone number(s) provided to provide me with the information I requested and other related information and services or programs that Sanofi Genzyme offers or sponsors, or other topics of interest. I understand that I am not required to provide this consent as a condition of purchasing any property, goods, or services from Sanofi Genzyme. To learn more about how your personal information is used or if you decide that you no longer want to receive information about Sanofi Genzyme's products and services, please visit Sanofigenzyme.com/privacy.

PRINT NAME: _____

PATIENT SIGNATURE (required): _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required for patients under 18 years old): _____ Date: _____

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