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

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. Not valid where prohibited by law. Upon registration, patient will received all program details.

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

Patient Services 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: ______

Patient weight: ______ kg ______ lb # of refills: ______ Directions: ______

Frequency: ______ Ancillary Supplies: Intravenous Access: Peripheral Port

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 Genzyme Corporation (together with its parents and affiliates, "Sanofi Genzyme") and its third-party business partners, vendors, and other agents ("Agents") (together with Sanofi Genzyme, "Sanofi"), for the purpose of providing product support services ("the Programs"). 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, and my decision to prescribe a Sanofi Genzyme product 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 below, I understand that provision of the product is not contingent on any purchase obligations. and that I will not seek reimbursement from any government program or third-party insurer for medication or supplies received free of charge under the Program, nor will the free product be sold, traded, or distributed for sale. 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 the below-named to (1) forward the above service request form and furnish any information on this form to the insurer of the below-named patient and (2) forward the above-named prescription, by fax or other mode of delivery, to our free goods pharmacy.

The prescriber is to comply with his/her 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.

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: ______

Code for Sanofi Genzyme internal use only

© 2020 Genzyme Corporation. All rights reserved. ALPROLIX and ELOCTATE are registered trademarks of Bioverativ Therapeutics Inc., a Sanofi company. MAT-US-2018340-v1.0-12/2020

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

My ELOCTATE: 1-855-693-5629
My ALPROLIX: 1-855-692-5776

INSTRUCTIONS FOR PATIENTS

PATIENT INFORMATION (required)

Patient name: ______________ DOB: ________ SSN (last 4 digits only): ________ Sex: M F Other

Parent/guardian name: ______________

Street address: ______________

City: ______________ State: ________ Zip: ________

Phone: ______________ OK to leave message Email: ______________

Language preference: English Spanish Other ________

Current therapy: ______________

Have you ever been on ELOCTATE or ALPROLIX? Yes No If Yes, date of first use? ________

Required for Factor Access program only:

1. Have you applied for Medicaid? (If yes, you must include your Medicaid denial letter. Letter must be within the last 90 days.)
   Yes No
2. Household Income (gross income from taxable resources minus allowable deductions) ______________
   Number in household ______________
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, state pharmaceutical assistance program, etc.?
		Do you reside in the United States or U.S. Territory?
		Are you being treated by a prescriber in the United States or U.S. Territory?

Pharmacy Benefit Manager (PBM): ______________ Group #: ________

Policy #: ________ Rx BIN #: ________ Rx PCN #: ________

Current specialty pharmacy: ______________ Specialty pharmacy phone number: ______________

Specialty pharmacy address: ______________ Specialty pharmacy fax number: ______________

Code for Sanofi Genzyme internal use only

© 2020 Genzyme Corporation. All rights reserved. ALPROLIX and ELOCTATE are registered trademarks of Bioverativ Therapeutics Inc., a Sanofi company. MAT-US-2018340-v1.0-12/2020

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

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 (together with its parents and affiliates, "Sanofi Genzyme"), and its third party business partners, vendors, and other agents ("Agents") (together with Sanofi Genzyme, "Sanofi") information about my disease, treatment, insurance coverage and payment for my therapy ("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 (including its Agents) 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 MyALPROLIX /MyELOCTATE 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 report regarding a Sanofi Genzyme 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 pharmacy with payment in order to obtain my Information. 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. However, if I do not sign this Authorization, Sanofi cannot provide me with support services. I understand that this Authorization expires 10 years from the date I signed unless subject to applicable law unless or until I withdraw (take back) this Authorization before then.

Further, 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 Genzyme ATTN: Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by emailing RBDPatientSolutions@sanofi.com.

Withdrawal of this Authorization will end further reliance on this Authorization (and my participation in the Program) but it will not invalidate reliance on the Authorization to use or disclose my Information before my notice of withdrawal is received and processed.

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.

PATIENT SIGNATURE: ____________________ PRINT NAME: ____________________ DATE: __________

PARENT/GUARDIAN SIGNATURE: (REQUIRED FOR PATIENTS UNDER 18 YEARS OLD)

____________________ ____________________ DATE: __________

(SIGNATURE) (Print Name)

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

(Print Name) (Relationship)

PATIENT SUPPORT SERVICES AUTHORIZATION

I authorize Sanofi to provide me with various therapy support services for which I am eligible, which may include but is not limited to: online support, patient education services, and compliance and persistency services, as well as any information or materials related to such 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. I understand and agree that Sanofi may contact me about such services and information by mail, e-mail, telephone call, fax, or text message to the mobile phone number I provided on the enrollment form (including autodialed; message and data rates may apply), 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 Genzyme 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 sending a written notice that includes my name, address and phone number, to Sanofi Genzyme ATTN: Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by emailing RBDPatientSolutions@sanofi.com. Sanofi Genzyme reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

By signing below, I certify that I have read and understand the Patient Support Program Authorization and agree to its terms.

PATIENT SIGNATURE: ____________________ PRINT NAME: ____________________ DATE: __________

PARENT/GUARDIAN SIGNATURE: (REQUIRED FOR PATIENTS UNDER 18 YEARS OLD)

____________________ ____________________ DATE: __________

(SIGNATURE) (Print Name)

Code for Sanofi Genzyme internal use only

© 2020 Genzyme Corporation. All rights reserved. ALPROLIX and ELOCTATE are registered trademarks of Bioverativ Therapeutics Inc., a Sanofi company. MAT-US-2018340-v1.0-12/2020

FINANCIAL ASSISTANCE PROGRAMS PATIENT AUTHORIZATION (CO-PAYMENT/PATIENT ASSISTANCE PROGRAM)

I confirm that my personal and insurance information provided on my enrollment form is accurate.

If applying for the MyAlprolix or MyEloctate Co-pay/Coinsurance Assistance Program (the “Co-pay Program”), I acknowledge and understand that (1) I am responsible for paying any out-of-pocket amounts over the program maximum; (2) in-patient medication is not covered by the program; (3) the Co-pay Program does not cover costs associated with administration of therapy such as office visits, supplies, procedures, or physician-related services, or other professional services; (4) the Co-pay Program will pay 100% of my eligible co-pay, coinsurance, and other out-of-pocket expenses up to the program maximum; and (5) patients who start utilizing state or federal government-funded health coverage during their enrollment period will no longer be eligible. I confirm that my personal and insurance information in this form are accurately completed. I certify that I am not a beneficiary of a federal or state healthcare program and that the product on this form is not covered by and will not be submitted for reimbursement under any state or federal program, including but not limited to Medicaid, Medicare, VA, DoD, TRICARE, or any state pharmaceutical assistance program. I will notify Sanofi Genzyme Patient Services immediately if my insurance status changes. By signing this Co-pay Program Authorization, I authorize Sanofi to use and share information about me with my healthcare providers, specialty pharmacy providers, and my insurance company for the purpose of coordinating my enrollment and participation in the Co-pay Program.

*Not valid for prescriptions covered by or submitted for reimbursement under Medicare, Medicaid, VA, DoD, TRICARE, or similar federal or state programs including any state pharmaceutical assistance programs. Not valid where prohibited by law. Savings may vary depending on patients' out-of-pocket costs. Upon registration, patient will receive all program details.

If applying for the Factor Access program (“PAP”), which provides drug at no cost to patients who are uninsured or underinsured and meet all eligibility requirements of the PAP, I understand that this is not a replacement program. I certify that all of the information submitted on my enrollment form, including information about my household income and the number of people in my household, is complete and accurate. Sanofi Genzyme RBD Patient Services may use my date of birth and/or additional demographic information as needed to access my credit information and may use information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. Continuation in the program is conditional upon timely verification of income. If requested, I agree to provide Sanofi with proof of income within thirty (30) days of the request. I acknowledge that no free product received via the PAP may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor may be sold, traded, or distributed for sale, and I certify that I will not submit any claims for any free product received via the PAP. I also certify that I will not count the free product received via the PAP towards my true out-of-pocket costs for any insurance plan I may have. I understand that this program is not meant to induce a physician to use or prescribe the product submitted on this enrollment form. I will notify Sanofi Genzyme RBD Patient Services immediately if my income or insurance status changes. Sanofi Genzyme reserves the right to review assistance requests based on patient need and to change program guidelines or terminate the program at any time without notification.

I also authorize Sanofi Genzyme and its Agents to contact me by mail, telephone, text message to the cell phone number I provided on the enrollment form (including autodialed; message and data rates may apply), or email in connection with Financial Assistance Programs and to inform me of available assistance programs, treatment and therapies, and insurance-related information. I understand a representative from Sanofi Genzyme 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 Sanofi Genzyme RBD Patient Services Financial Assistance Programs 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 writing to Sanofi Genzyme ATTN: Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by sending an email to: RBDpatientsolutions@sanofi.com. Sanofi Genzyme reserves the right to rescind, revoke, or amend the Programs and discontinue support at any time without notice.

PATIENT SIGNATURE: ____________ PRINT NAME: ____________ DATE: ________

PARENT/GUARDIAN SIGNATURE: (REQUIRED FOR PATIENTS UNDER 18 YEARS OLD)

____________ (SIGNATURE) ____________ (Print Name) DATE: ________

AGREE TO RECEIVE RELEVANT SANOFI GENZYME MARKETING COMMUNICATIONS (OPTIONAL)

Sanofi Genzyme would like to contact you to provide additional information about our products and financial assistance programs or contact you to conduct market research. You must be eighteen (18) years or older to enroll. Your information will not be sold to any third party but may be provided to regulatory authorities if required. I authorize Sanofi Genzyme to contact me by mail, email, fax, and/or telephone, including calls and text messages (message and data rates may apply) made using an automatic telephone dialing system (autodialer) or a prerecorded voice, at the telephone number(s) provided on my enrollment form 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 and that I may participate in the Programs if I do not sign this optional marketing authorization. My personal data will be processed and stored in electronic databases controlled by or on behalf of Sanofi Genzyme. To learn more about how your information is used or if you decide that you no longer want to receive information about Sanofi Genzyme's products and services, please send a letter to Sanofi Genzyme, RBD Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142.

PATIENT SIGNATURE: ____________ PRINT NAME: ____________ DATE: ________

PARENT/GUARDIAN SIGNATURE: (REQUIRED FOR PATIENTS UNDER 18 YEARS OLD)

____________ (SIGNATURE) ____________ (Print Name) DATE: ________

Code for Sanofi Genzyme internal use only

© 2020 Genzyme Corporation. All rights reserved. ALPROLIX and ELOCTATE are registered trademarks of Bioverativ Therapeutics Inc., a Sanofi company. MAT-US-2018340-v1.0-12/2020