

APPLICATION INSTRUCTION GUIDE

To ensure that you maximize the full range of services for Sanofi Patient Connection, we have provided this instructional sheet for your convenience. For additional information on how the Program can assist your office and patients, you may reach us at:

Phone: 1.888.847.4877
Fax: 1.888.847.1797

P.O. Box 222138
Charlotte, NC 28222-2138

REIMBURSEMENT CONNECTION

- Please complete all fields in Sections I, II, III and IV.
 - We do not require the patient's income information OR the patient's signature on the Patient Authorization Form.
- In Section III, please indicate the provider Tax ID, NPI, and State License numbers.
- In Section IV, the Provider must indicate if there is a patient consent on file.
- Submit the application (pages 3–4) via Fax or US Mail

RESOURCE CONNECTION

If the "Yes" box is checked in Section V, our team will contact you or your patient to help identify resources provided by other organizations.

PATIENT ASSISTANCE CONNECTION



- Please complete sections I, II, III, IV, and V.
- In Section III, please indicate the provider Tax ID, NPI, and State License numbers.
- Please be sure to indicate if we may contact your patient for Resource Connection in Section V
- Please have the patient sign the Patient Authorization Form on page 5.
- Submit the application (pages 3-4), authorization form (page 5), and income documentation via Fax or US Mail.
- If applying for Drug Replacement, please also submit a copy of the claim denial, flow sheet(s) and drug inventory log (with patient name, product NDC/ Lot #, dates of service & total dosage).

PROGRAM ELIGIBILITY

- An application must be submitted for each patient. Applications can be submitted via fax, or US mail.
- Patient must be a US citizen or resident, with a Social Security Number.
- Patient must be under the care of a licensed healthcare provider who is authorized to prescribe, dispense, and administer medicine in the US.
- Patient must meet the appropriate financial criteria for patient assistance services (PAP):
 - Annual household income of ≤500% of current Federal Poverty Level (FPL) for oncology products and ≤250% for all other eligible PAP products.
- For Vaccines, patient must be 19 years of age or older (except IMOVAX RABIES and IMOGAM RABIES HT)

INCOME DOCUMENTATION

- Copy of most recently filed U.S. Income Tax Return, IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040PR, or
- Copy of W-2, **or** Copy of most recent Social Security/Disability monthly check, Award Letter, Benefit Statement, 1099, **or** Copy of most recent pay stub plus most recently filed U.S. Income Tax Return, or
- Copy of most recent Social Security Statement.

PRODUCT SELECTION:

Which drug do you need assistance with?

PRESCRIPTION MEDICATIONS

Apidra® (insulin glulisine [rDNA] origin) Injection Lantus® (insulin glargine [rDNA] injection)

Clolar® (clofarabine) Injection Elitek® (rasburicase) Eloxatin® (oxaliplatin injection)

Jevtana® (cabazitaxel) Injection Leukine® (sargramostim) Mozobil® (plerixafor injection)

Eligard® (leuprolide acetate) suspension

Multaq® (dronedarone) Tablets Priftin® (rifapentine) Tablets

Rilutek® (riluzole) Tablets

VACCINES

Adacel® (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine adsorbed)

Tenivac® (tetanus and diphtheria toxoids adsorbed)

Imogam® Rabies-HT Immune Globulin, [Human] USP, Heat Treated

Imovax® Rabies Vaccine [Human Diploid Cell]

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)

TheraCys® (BCG Live [Intravesical])

Please Note: In order to process this application, this form needs to be completed as outlined on the instruction sheet. Patient and Prescriber signatures are required for Patient Assistance (PAP) services. Information supplied on this form will be held in strict confidence and will only be used for the administration of this program.

SECTION I: Patient Information

First Name:		Middle Initial:	Last Name:		
Address:					
City:	State:	Zip Code:	Phone #:	Email:	
Social Security #:		Date of Birth:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Total # of people in the household: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> Other				Total Yearly Income:	

SECTION II: Treatment and Prescribing Information

Drug #1:	Dosage:	Frequency:	Quantity:	# of Refills:	BSA/Weight:
Drug #1: ICD-9/Diagnosis:					
Drug #2:	Dosage:	Frequency:	Quantity:	# of Refills:	BSA/Weight:
Drug#2: ICD-9/Diagnosis:					
Drug #3:	Dosage:	Frequency:	Quantity:	# of Refills:	BSA/Weight:
Drug#3 ICD-9/Diagnosis:					

SECTION III: Physician Information

Physician Name:		Physician State License#:	Physician NPI #:	Physician Tax ID #:	
Facility Name:		Facility Phone #:		Facility Fax #:	
Facility Address:			City:	State:	Zip Code:
Facility Type: <input type="checkbox"/> Community Practice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Infusion Center <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Hospital Outpatient					
Primary Contact Name:		Title/Role:	Primary Contact Email:		
Physician Shipping Address (if different from Facility address listed above):			City:	State:	Zip Code:
Shipping Contact Person (if different from Primary Contact listed above):			Shipping Contact Phone #:		

To the best of my knowledge the information contained in this application is complete and accurate and this patient has no prescription insurance coverage either private or public (e.g. Medicaid), and meets the required income limits for participation in this Program. If I become aware of a change in income or insurance status that may effect Program participation of this patient, I will alert Program Sponsor. I understand that Sanofi U.S. and/or The Sanofi Foundation for North America has the right to modify or terminate this program at any time without notice. I attest that I am not on the HHS/OIG list of Excluded Individuals. My signature certifies that 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. I agree to participate in any recall of the product initiated by the manufacturer.

Physician or Licensed Prescriber Signature (required - no stamps)

Date



Patient Certification and Authorization to Disclose Information:

Patient Name (Please Print): _____ states 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, U.S., its affiliated companies (i.e. Sanofi Pasteur U.S. and Genzyme), 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 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 U.S. 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 or Guardian*

Date

*If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally)

Patient Social Security Number

Date of Birth

Sanofi U.S., 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.