S OFI

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P: 1.888.847.4877 · F: 1.888.847.1797
P.O. Box 222138 · Charlotte, NC · 28222-2138

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:

☐ Clinical Support Services ☐ Transportation ☐ Patient Advocacy Support ☐ Nutritional Supplements (groceries, food banks, etc.)

☐ Health Supplies/Cosmetic Aids (wigs, scarves, etc.) ☐ Home Care Services (shelter, utilities, etc.) ☐ Other:_____

If patient speaks a language other than English, please indicate language here:_____

If the Yes box is checked, our team will contact the patient and/or the provider to help identify resources provided by other organizations.

5. 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 required income verification options for your financial eligibility assessment for Patient Assistance Connection:

☐ 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 agents 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.

☐ **Option 2: 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

Patient Name (Please Print): I,_____, state that the information and documents provided in connection with this application are complete and accurate. 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 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 understand that it is my responsibility to follow-up with my prescriber or the Program to make sure that my re-orders, as appropriate, are shipped in a timely manner so I do not run out of medication. 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.

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:_____ Relationship:_____ Phone #:_____

SIGN HERE _____ _____ _____

Patient Signature | Printed Name | Date

APPLICATION CHECKLIST *(application will be delayed if all information is not received)*

- ☐ Signatures of prescriber and patient (required for Patient Assistance Connection only)
- ☐ Copy of income document(s) must be attached if patient has chosen Option 2 for income verification
- ☐ The following must be completed as needed: Dosage, Diagnosis Code, State License Number, Insurance Details
- ☐ HIPAA consent checked

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(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
- 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)

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