CareConnectPSS®
Patient Assistance Program Application

SANOFI GENZYME

CareConnectPSS® Patient Assistance Program Description

The CareConnectPSS Patient Assistance Program ("Patient Assistance Program," "PAP," or the "Program") was established in the United States to provide certain Sanofi Genzyme therapies (specified in Section 6 below) at no cost to eligible patients who do not have health insurance or cannot access an eligible product under the terms of their insurance plan(s), until insurance coverage for the patient's prescribed, eligible product is secured. Patient Assistance Program and eligibility criteria include the following:

- Patient must not have insurance coverage or not have access to the prescribed, eligible Sanofi Genzyme product (specified in Section 6 below) under the terms of the patient's insurance plan(s)
- Patient must live in the US or a US territory
- Patient must have a valid prescription from a health care provider licensed in the US or a US territory
- The uninsured patient must be willing to work with a Case Manager to enroll in a health plan for product insurance coverage when possible
- Other terms and conditions of the Program apply

How to Apply for the CareConnectPSS® Patient Assistance Program

Instructions for Healthcare Providers:

- Ensure Sections 1–2 below of the PAP Application are completed
- You must complete Section 3 and Section 4
- You must read, understand, and sign the Prescriber Certification in Section 5
- Your patient must read, understand, and sign the Permission to Provide CareConnect PSS Patient Assistance Program Services in Section 7 and the Permission to Share Health Information in Section 8

Instructions for Patients:

- If you wish to participate in the CareConnectPSS Patient Assistance Program, you must read, understand, and sign the Permission to Provide CareConnectPSS Patient Assistance Program Services in Section 7 and the Permission to Share Health Information in Section 8

Once completed, please retain a copy of this Application for your records and promptly return the original to Sanofi Genzyme by mail, email, or fax.

- By Mail: Sanofi Genzyme, Attn: Case Management, 50 Binney Street, 6th floor, Cambridge, MA 02142
- By Email: CareConnectPSS_accessprograms@sanofi.com
- By Fax: 1-908-243-2430

The CareConnectPSS team will reach out to both the HCP and the patient to communicate the decision regarding your application.

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Do not include patient medical records with this application.

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1. Patient Information

Name (First, Last) ☐ Male ☐ Female

Street Address | City | State

Zip | DOB Month/Day/Year | Email

Mobile Phone | Home Phone

2. Insurance Information

Complete payer information below. You may also include copies of insurance cards (front and back side), but still complete the information below. If the patient is uninsured, please indicate by checking the box below.

Insurance? ☐ Yes ☐ No

Primary Insurance | Policy ID

Group # | Phone

Policy Holder Name | Relationship to Patient

Pharmacy Plan Name | Policy ID #

Group # | Rx Bin #

Rx PCN # | Phone

Secondary Insurance | Policy ID #

Group # | Phone

Policy Holder Name | Relationship to Patient

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3. Treatment and Prescribing Information

Patient Name (First, Last) _____ Date of Birth _____

Street Address _____ City _____ State _____

Please indicate product below and complete related treatment and prescribing information:

Please see Section 6 for complete list of eligible products

_____
Product

_____ _____ _____ _____
ICD-10 Code | Weight (kgs / lbs.) | Dose | Frequency

4. Prescribing Physician Information

Prescriber Name (First, Last) _____

_____ _____ _____ _____
License # | NPI # | Tax ID | DEA #

Facility Name _____

Facility Address _____

City _____ State _____ Zip _____

Office Contact Name _____ Title / Role _____

Phone _____ Fax _____ Email _____

5. Prescriber Certification

I certify that the information provided in this Patient Assistance Program Application ("Application") is current, complete, and accurate to the best of my knowledge. I certify that the Sanofi Genzyme product identified above is medically necessary for the above-named patient and that I am authorized under state law to prescribe and dispense the medication indicated above. I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification, medical information, and insurance information to Sanofi Genzyme and its agents and representatives. I understand that any information provided is for the sole use of the Sanofi Genzyme CareConnectPSS Patient Assistance Program (the "Program") to verify my patient's insurance coverage; to assess, if applicable, my patient's eligibility for participation in the Program; and to otherwise administer the Program and related services. I understand that I am under no obligation to prescribe any Sanofi Genzyme product, and I acknowledge that I have not received and will not receive any benefit from Sanofi Genzyme or its agents or representatives for prescribing a Sanofi Genzyme product. My signature certifies that any prescription product received from the Program as a result of this Application will be used for the above-named patient only; will not be resold or offered for sale, trade, or barter; and will not be returned for credit. Neither I nor any of my agents or representatives will seek payment from any payer, patient, or other source for product received from the Program.

_____ _____
Prescriber Signature (REQUIRED) Date

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6. Eligible Products

• **Aldurazyme® (laronidase)**	*Please see full Prescribing Information including Boxed WARNING available at www.alduarzyme.com*
• **Cerezyme® (imiglucerase for injection)**	*Please see full Prescribing Information available at www.cerezyme.com*
• **CERDELGA® (eliglustat) capsules, for oral use**	*Please see full Prescribing Information available at www.cerdelga.com*
• **Fabrazyme® (agalsidase beta)**	*Please see full Prescribing Information available at www.fabrazyme.com*
• **Lumizyme® (algucosidase alfa)**	*Please see Prescribing Information including Boxed WARNING available at www.lumizyme.com*
• **Nexviazyme™ (avalglucosidase alfa-ngpt)**	*Please see Prescribing Information including Boxed WARNING available at www.nexviazyme.com*

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7. Permission to Provide CareConnect PSS® Patient Assistance Program Services

Please read this Permission carefully and if you agree with its terms, sign, and date where indicated below.

Patient Name (First, Last) _____ Date of Birth _____

I understand that if my Patient Assistance Program Application ("Application") is approved, I will be enrolling in the CareConnectPSS Patient Assistance Program (the "Program") sponsored by Sanofi Genzyme and its affiliates (collectively, "Sanofi Genzyme"). The Program provides eligible Sanofi Genzyme therapies (specified in Section 6 above) at no cost for the disease indications respectively specified in the product labels for eligible products to uninsured patients or patients who do not have access to a prescribed, eligible product under the terms of their insurance plan(s). Other terms and conditions of the Program apply. The Program does not cover any Product that was administered or dispensed prior to approval of my Application for the Program and my Application may not be backdated. I understand that Sanofi Genzyme reserves the right at any time and without notice to modify or change eligibility criteria or discontinue this Program.

The Program also provides personalized support and services related to the rare disease with which I have been diagnosed and/or Sanofi Genzyme therapy, including care coordination; information on health insurance benefits for Sanofi Genzyme therapy; financial assistance for Sanofi Genzyme therapy; educational resources; and personnel knowledgeable about the rare disease with which I have been diagnosed and health insurance matters (together, the "Services"). I permit Sanofi Genzyme and its third-party business partners, vendors, and other agents (together, "Agents") to provide me with Services for which I am eligible under the Program, as described above and as may be added in the future.

I permit Sanofi Genzyme and its Agents (i) to contact me by mail, telephone, or email with disease information or with information about Sanofi Genzyme products, promotions, services, or research studies, and (ii) to ask my opinion about such information and topics, including in the form of market research and disease-related surveys. I understand that 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 am not required to enroll in the Program or sign this Permission to enroll in the Program. A decision by me not to enroll in the Program or sign this Permission will not affect my ability to receive my Sanofi Genzyme therapy, as prescribed by my physician. However, if I do not sign this Permission, I understand that I will not be enrolled in the Program or able to participate in the Program. I understand that this Permission shall remain in effect throughout my participation in the Program, unless and until I cancel this Permission. I may change my mind and cancel individual services offered by the Program or cancel entirely this Permission for the Program at any time by notifying a Program representative by calling 800-745-4447 and selecting Option 3; writing to Sanofi Genzyme, Attn: Case Management, 50 Binney Street, 6th floor, Cambridge, MA 02142; faxing my cancellation to 908-243-2430; or emailing CareConnectPSS_accessprograms@sanofi.com. I understand that canceling this Permission will end my participation in the Program.

I attest that the information and documents I provide in connection with this Application are complete and accurate. I agree to inform immediately a Program representative and my Healthcare Provider if my insurance status changes during my participation in this Program.

By signing below, I certify that I have read and understand the Permission to Provide CareConnectPSS Patient Assistance Program Services and agree to its terms.

Print name of Patient or Patient Representative _____ *Date* _____

Signature of Patient or Patient Representative _____ *Date* _____

If signed by the Patient's representative, provide a description of the representative's relationship to the Patient and such person's authority to act for the Patient (e.g., health care power of attorney).

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8. Permission to Share Health Information

Please read this Permission carefully and if you agree with its terms, sign, and date where indicated below.

Patient Name (First, Last) _____ Date of Birth _____

I understand that if my Patient Assistance Program Application is approved, I will be enrolling in the CareConnectPSS® Patient Assistance Program (the "Program") sponsored by Sanofi Genzyme and its affiliates (together, "Sanofi Genzyme"). The Program provides eligible Sanofi Genzyme therapies (specified in Section 6 above) at no cost for the disease indications respectively specified in the product labels for eligible products to uninsured patients or patients who do not have access to a prescribed, eligible product under the terms of their insurance plan(s). Other terms and conditions of the Program apply. The Program also provides personalized support and services related to the rare disease with which I have been diagnosed and/or Sanofi Genzyme therapy, including care coordination; information on health insurance benefits for Sanofi Genzyme therapy; financial assistance for Sanofi Genzyme therapy; educational resources; and personnel knowledgeable about the rare disease with which I have been diagnosed and health insurance matters (together, the "Services"). I permit my (i) current and former treating healthcare providers and staff; (ii) health insurers that pay/have paid for health care products and services provided to me; and (iii) pharmacies that fill/have filled prescriptions for my Sanofi Genzyme therapy ((i), (ii), and (iii) together, the "Disclosing Parties") to disclose health information about me, including information related to my medical condition and treatment, health insurance benefits and claims, prescription for my Sanofi Genzyme therapy (including fill/refill information), and referral to and enrollment in the Program (my "Information") for the purposes and to the parties described in this Permission.

I permit the use and disclosure of my Information for the following purposes: (i) enrolling me in and providing Services under the Program, which include insurance benefit verification; (ii) considering whether I am eligible for CareConnectPSS financial assistance programs and any other Sanofi Genzyme financial assistance programs for rare disease patients (including free goods, humanitarian, and co-pay programs); and (iii) carrying out internal business operations. I also permit the use and disclosure of my Information for the purposes of allowing Sanofi Genzyme (i) to send me disease information or information about Sanofi Genzyme products, promotions, services, or research studies; and (ii) to ask my opinion about such information and topics, including in the form of market research and disease-related surveys ((i) and (ii) together, the "Communications").

I permit my Information to be disclosed to the following parties: Sanofi Genzyme and its third-party business partners, vendors, and other agents (together, "Agents"). I also permit Sanofi Genzyme and its Agents to use and share Information with each other and the Disclosing Parties for the purposes described in this Permission. I also permit Sanofi Genzyme and its Agents to de-identify my Information and use it in providing services to me and performing research, education, business analytics, and marketing studies or for other commercial purposes such as, for example, estimating sales.

I understand that Sanofi Genzyme and its Agents agree to use and disclose my Information consistent with the terms of this Permission or as otherwise allowed by law. However, once my Information has been disclosed to a third party, I understand that federal privacy laws may no longer protect it from further disclosure. Persons or parties that receive my Information under this Permission may not be required by privacy laws (such as HIPAA) to protect the information, and they may share it with others without my permission, if permitted by laws that apply to them.

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8. Permission to Share Health Information (cont.)

Please read this Permission carefully and if you agree with its terms, sign, and date where indicated below.

Patient Name (First, Last) _____ Date of Birth _____

I understand that I am not required to sign this Permission. A decision by me not to sign this Permission will not affect my ability to obtain medical care, health insurance benefits, access to health benefits, or my Sanofi Genzyme therapy. However, if I do not sign this Permission, I understand that I will not be able to participate in the Program. I understand that this Permission shall remain in effect throughout my participation in the Program, unless and until I cancel this Permission. In the event state law limits the duration of forms like this Permission, this Permission shall remain in effect for the longest period permitted under applicable law. I may change my mind and cancel this Permission at any time by calling 800-745-4447 and selecting Option 3; writing to Sanofi Genzyme, Attn: Case Management, 50 Binney Street, 6th floor, Cambridge, MA 02142; faxing my cancellation to 908-243-2430; or emailing CareConnectPSS_accessprograms@sanofi.com. I understand that canceling this Permission will end my participation in the Program and will not affect any use or disclosure of the Information made before my request is received and processed.

Print name of Patient or Patient Representative _____ *Date* _____

Signature of Patient or Patient Representative _____ *Date* _____

If signed by the Patient's representative, provide a description of the representative's relationship to the Patient and such person's authority to act for the Patient (e.g., health care power of attorney).

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