Sanofi Patient Connection
Phone 1-888-847-4877 · Fax 1-888-847-1797

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

SANOFI Foundation for North America

- 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.

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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
- ☐ Lovenox® (enoxaparin sodium injection)
- ☐ Multaq® (dronedarone) Tablets
- ☐ Rilutek®(riluzole) Tablets
- ☐ Priftin® (rifapentine) 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: ☐ Male ☐ Female
Total # of people in the household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 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: ☐ Community Practice ☐ Physician's Office ☐ Infusion Center ☐ Hospital Inpatient ☐ 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**

SECTION IV: Reimbursement Connection (Insurance Verification Services)

☐	Check here for Insurance Verification only (Please note: No income information or documentation is required.
☐	Check here for Insurance Verification and Patient Assistance Program determination if no coverage is found (Please note: Income documentation and patient signature IS required).

Do you have the patient's HIPAA consent on file? ☐ Yes ☐ No

Sanofi Patient Connection must confirm that your office has a written patient HIPAA consent on file to conduct insurance services.

Primary Insurance:		Secondary Insurance:	
Policy #:	Group #:	Policy #:	Group #:
Insurance Phone #:		Insurance Phone #:	
Policy Holder Name:		Policy Holder Name:	
Policy Holder Date of Birth:		Policy Holder Date of Birth:	

SECTION V: Resource Connection

May the Program contact the patient directly for referrals to external resources? ☐ Yes ☐ No

Please mark which referrals/resources your patient may be interested in if available:

☐ Co-pay Programs	☐ Clinical Support Services	☐ Home Care Services/ Shelter/Utilities	☐ Patient Advocacy Support
☐ Transportation	☐ Nutritional Supplements, Groceries and Food Banks	☐ Cosmetic Aids (wigs, scarves, makeup, etc.)	☐ Other:_____

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

Please fax this completed Enrollment form, authorizations and other documents to Sanofi Patient Connection at
1-888-847-1797
Or mail to:

Sanofi Patient Connection
PO Box 222138
Charlotte, NC 28222-2138

Also coming soon, the Sanofi Patient Connection Provider Portal. The Provider Portal is a resource for your practice to enroll and manage patients in Sanofi Patient Connection. It will be tailored to fit busy practice needs by providing quick and easy real time access to information at your fingertips and will soon be available to you.

Sanofi Patient Connection reserves the right to verify all information provided by healthcare professionals, suspend participation where inadequate information is provided, and limit enrollment based on available sources.

For full prescribing information including boxed WARNINGS, please call 1-800-633-1610 or visit https://www.sanofi.us

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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.