CareASSIST®
Patient Support by Sanofi Genzyme

SANOFI GENZYME

Enrollment Application

The CareASSIST Patient Support Program offers access support for eligible patients prescribed Sanofi Genzyme Oncology medications.

Select your treatment: ○ ELITEK® (rasburicase) ○ JEVTANA® (cabazitaxel) injection ○ SARCLISA® (isatuximab-irfc)

Some sections will need to be completed by a healthcare provider. Forms can be submitted by fax or mail, or completed online by a healthcare provider at **CareASSISTProviderPortal.com**.

1. Type of Support Requested Check all that apply

Access and Reimbursement

Assistance navigating the insurance process.

- ○ Prior authorization assistance
- ○ Benefits verification services
- ○ Claims/appeals assistance

Financial Assistance

Eligible patients may qualify for programs and services that may help with the cost of treatment.

- ○ CareASSIST Copay Program
- ○ CareASSIST Patient Assistance Program (PAP)

In addition to all required fields, please complete sections 4 and 7b

○ Resource Support

Independent support services for patients and caregivers, as well as product ordering and replacement information.

In addition to all required fields, please complete section 5

2. Patient Information Please complete all required fields. Required fields are marked with an asterisk*

First Name* MI Last Name* Gender ○ M ○ F

Address* City* State* ZIP Code*

Phone #* ○ Home ○ Mobile Date of Birth*

Primary Language (if not English) Email

Known Drug Allergies ○ None ○ Yes (if yes, list known allergies and associated reactions)

Concomitant Medications ○ None ○ Yes (if yes, list concomitant medications)

Alternate Contact/Caregiver Information (optional)

First Name Last Name Phone # ○ Home ○ Mobile

Relationship to Patient Email

Does the patient consent for the program to contact the caregiver? ○ Yes ○ No

Contact Us

For any questions or assistance, please call 1-833-WE+CARE (1-833-930-2273), Mon – Fri, 9 AM – 8 PM ET.
Please complete and return all pages to CareASSIST by Sanofi Genzyme, PO Box 220616, Charlotte, NC 28222, or by fax to 1-855-411-9689.

Please complete all fields unless they are specified for a program you are not applying for.

Patient Name _____ Date of Birth _____

3. Insurance Information

Is the patient insured? ○ Yes (please provide insurance information) ○ No (move to next section)

Primary Insurance Name	Secondary Insurance Name
Policy #	Policy #
Policy Holder Name	Policy Holder Name
Relationship to Patient	Relationship to Patient
Insurance Phone #	Insurance Phone #
Group #	Group #

4. Patient Household Income Information **Required if requesting PAP**

Total # of people in the household _____

Annual household income $ _____

5. Support Services **Required if requesting Resource Support**

Does the patient wish to have the program contact them to help identify resources provided by other organizations?

○ Yes ○ No

If yes, please mark which resources the patient may be interested in learning about, if available:

○ Clinical support services
○ Transportation assistance
○ Patient advocacy support
○ Food and nutrition programs
○ Health supplies/cosmetic aids
○ Home care services
○ Other _____

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Patient Name _____ Date of Birth _____

6. Prescriber Information

Prescriber Name | Prescriber Type | State Where Licensed

State License # | NPI # | Tax ID #

Physician Name (if different from prescriber) | State Where Licensed | State License #

Facility Name | Facility Type ○ Prescriber Office/Clinic ○ Hospital Outpatient ○ Hospital Inpatient

Facility Address | City | State | ZIP Code

Primary Contact Name | Title/Role

Primary Phone # | Primary Fax # | Primary Email

(FOR SARCLISA) If obtaining through specialty pharmacy, check which specialty pharmacy commercial prescription was sent to:
○ CVS Specialty ○ Biologics

7. Medication Information

7a. Product See URLs below for ICD-10 code information	ICD-10 codes	7b. Prescription Information Required if requesting the Patient Assistance Program			
		Dosage	Quantity (no. of doses)	No. of refills	Newly enrolled or prior patient
○ ELITEK® (rasburicase)* **elitekpro.com/resources**	**Write in code**	Administer _____ mg as an IV infusion over 30 minutes daily for up to 5 days	__/5 (5 max)	N/A	○ New ○ Prior
○ JEVTANA® (cabazitaxel) injection* **jevtanapro.com/resources**	**Write in code**	Administer _____ mg as an IV infusion over 1 hour every 3 weeks	__/1 (1 max)	____ PRN refills for one year	○ New ○ Prior
○ SARCLISA® (isatuximab-irfc)	**Select code** ○ C90.00 ○ C90.01 ○ C90.02	Administer _____ mg as an IV infusion according to the rates specified in section 2.5 of the full Prescribing Information	__/2 (2 max)	____ PRN refills for one year	○ New ○ Prior

Previous treatments (include start/end dates) _____

*__Please see full Prescribing Information, including Boxed WARNINGS.__
Full US Prescribing Information for all Sanofi Genzyme CareASSIST-supported products can be accessed at www.sanofi.us/en/products-and-resources/prescription-products.
The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

8. Prescriber Signature and Declaration **Please note that prescriber signatures cannot be stamped**

Provider Sign Here _____

Prescriber Signature (required – no stamps) | Printed Name | Date

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Patient Name _____ Date of Birth _____

8. Prescriber Declaration Continued from page 3

My signature on page 3 above certifies that the person named on this form is my patient, the information provided on this application is complete and accurate to the best of my knowledge, and the medication received free of charge from the CareASSIST Patient Assistance Program in response to this application, if any, is exclusively for the patient named on this form. It is my professional judgment that each medication selected in section 7 is medically necessary for the patient named on this form. I hereby certify that no medication received free of charge under the CareASSIST Patient Assistance Program shall be offered for sale, trade, or barter, and that no claim for reimbursement will be submitted to Medicare, Medicaid, or any third-party payer for medication received free of charge under the CareASSIST Patient Assistance Program. I consent to Sanofi Genzyme and its affiliates and agents contacting me by fax, phone, mail, or email to confirm receipt of this medication and/or to provide additional information about this medication or CareASSIST. I understand that Sanofi Genzyme may revise, change, or terminate any program services at any time without notice to me.

9a. Patient Income Certification For Patient Assistance Program

I certify that the number of people in my household and my household income provided in section 4 of this form are true and accurate to the best of my knowledge. To qualify for the CareASSIST Patient Assistance Program, I understand that I must meet certain income and other eligibility requirements. CareASSIST and its authorized third-party agents 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 CareASSIST with proof of income within thirty (30) days of the request. I agree to immediately inform CareASSIST and my doctor/healthcare provider if my income or insurance status changes during the course of my participation in the CareASSIST Patient Assistance Program.

9b. Patient Certification For all applicants

I hereby authorize Sanofi Genzyme and its affiliates and agents to provide services to me under the CareASSIST Patient Support Program, as described in this form and as may be supplemented in the future. Such services may include: determining if I am eligible to enroll in and/or receive services from CareASSIST, including access and reimbursement assistance services, patient assistance programs, and resource services; investigating my health insurance coverage benefits; providing information on prior authorizations and appeals of denied claims for coverage/reimbursement; referring me to, or determining my eligibility for, other programs and/or alternate sources of funding; and providing information on other independent support services that may be available to me (together, the "Services").

If applying to the CareASSIST Copay Program, I agree to my enrollment in such program if confirmed as eligible. I understand that copay information will be sent to my physician or the designated specialty pharmacy, and any assistance with my applicable cost-sharing or copayment for each medication selected in section 7 will be made in accordance with the Program terms and conditions.

I authorize Sanofi Genzyme and its affiliates and agents to contact me by mail, telephone, or email with information about CareASSIST, Sanofi Genzyme products, my condition, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I understand that I may be contacted by Sanofi Genzyme in the event that I report an adverse event.

I understand that I do not have to enroll in CareASSIST or receive the communications described above (the "Communications") and that I can still receive Sanofi Genzyme products as prescribed by my physician. I may opt out of receiving Communications and/or individual Services, including the CareASSIST Patient Assistance Program, or opt out of CareASSIST entirely at any time by notifying a CareASSIST representative by telephone at **1-833-WE+CARE** (1-833-930-2273) or by sending a letter to CareASSIST, PO Box 220616, Charlotte, NC 28222. I also understand that the Services may be revised, changed, or terminated at any time.

Patient Sign Here

_____ _____ _____

Patient/Legal Representative Signature | Printed Name | Date

_____

Relationship to patient (if signed by someone other than the patient)

Contact Us

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Patient Name _____ Date of Birth _____

10. Patient Authorization to Disclose Information For all applicants

I authorize my healthcare providers and staff; my health insurer, health plan, or programs that provide me healthcare benefits (together, "Health Insurers"); and any specialty pharmacies that dispense my medication to disclose to Sanofi Genzyme, and its affiliates and agents, health information about me, including patient-related information provided throughout this form and related to my medical condition, treatment with prescribed Sanofi Genzyme therapies, health insurance coverage, claims, prescriptions, and referral to and enrollment in the CareASSIST Patient Support Program and Copay Program (together, "My Information"). My healthcare providers, Health Insurers, specialty pharmacies, and Sanofi Genzyme (including its agents and affiliates) may use and disclose My Information for the purposes of providing certain support services, including:

- To determine if I am eligible to enroll in and/or receive services from CareASSIST, including access and reimbursement assistance services, patient financial assistance programs, and resource services;
- For the operation and administration of CareASSIST;
- To investigate my health insurance coverage benefits;
- To assist with prior authorization for coverage/ reimbursement;
- To assist with the status of appeals of denied claims for coverage/reimbursement; and
- To refer me to, or to determine eligibility for, other programs and/or alternate sources of funding—such as Medicaid, healthcare exchanges, Medigap, state pharmaceutical assistance programs (SPAPs), and charitable foundations—that may be available to assist me with the costs of my medications.

I further authorize Sanofi Genzyme and its affiliates and agents 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 Genzyme may receive from other sources. I understand that Sanofi Genzyme and its affiliates and agents may share My Information, including identifiable health information, among themselves in order to de-identify it for these purposes and as needed to perform the Services or to send the Communications. I understand and agree that Sanofi Genzyme and its affiliates and agents may use My Information for these purposes and may share My Information with my doctors, specialty pharmacies, and Health Insurers.

I understand and agree that my healthcare providers, Health Insurers, and specialty pharmacies may receive remuneration from Sanofi Genzyme in exchange for disclosing My Information to Sanofi Genzyme and/or for providing me with support services in connection with CareASSIST.

Once My Information has been disclosed to Sanofi Genzyme, I understand that federal privacy laws may no longer protect it from further disclosure. However, Sanofi Genzyme agrees to protect My Information by using and disclosing it only for the purposes authorized in this authorization or as otherwise required by law.

I understand that I may have certain rights under applicable data privacy laws regarding My Information, including the right to access My Information held by Sanofi Genzyme. For further information regarding these rights, please reference the Sanofi Genzyme Global Privacy Policy at www.sanofi.com/en/our-responsibility/sanofi-global-privacy-policy.

I understand that if I decline to sign this authorization, I will not be able to participate in CareASSIST, but it otherwise will not affect my eligibility to obtain medical treatment, my ability to seek financial assistance from other sources, or my insurance enrollment or eligibility for insurance coverage.

Furthermore, I understand that I may withdraw (take back) this authorization at any time by mailing or faxing a written request to CareASSIST, PO Box 220616, Charlotte, NC 28222; Fax: 1-855-411-9689. Withdrawal of this authorization will end further uses and disclosures of My Information by the parties identified in this authorization except to the extent those uses and disclosures have been made in reliance upon this authorization prior to my request to withdraw this authorization.

This authorization expires 18 months from the date support is last provided under any CareASSIST program, subject to applicable law, unless I withdraw it earlier. I understand that I may request a copy of this authorization.

Patient Sign Here _____ _____ _____

Patient/Legal Representative Signature | Printed Name | Date

_____

Relationship to patient (if signed by someone other than the patient)

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