CareASSIST enrollment form

● *Required fields*

CareASSIST is a support program by Sanofi for patients prescribed SARCLISA® (isatuximab-irfc). When patients are enrolled in **CareASSIST**, they are connected with a dedicated Case Manager who can provide access and reimbursement support, financial assistance, if eligible, and other helpful resources.

Treatment start date
Leave blank if unknown.

Date of patient's first infusion.

Line of therapy
Leave blank if unknown.

Patient information

First name ● | MI | Last name ●

Preferred name

Gender ○ M ○ F ○ Other ○ Prefer not to answer

Sanofi and its partners recognize that patients may not identify as male or female. However, many insurance companies still require that one of the fields be used for each of their members. Please indicate the gender on file with your patient's insurance company.

Date of birth

Address 1 ● | Address 2 | City ●

State ● | ZIP code ● | Primary phone ● ○ Home ○ Mobile

Secondary phone | Preferred time to call ○ Morning ○ Afternoon ○ Evening

Email | Patient's preferred language

Caregiver information/alternate contact

Does the patient consent to the program contacting their caregiver? ○ Yes ○ No

First name | Last name

Primary phone | Preferred time to call ○ Morning ○ Afternoon ○ Evening

Health insurance information

Please include a copy of the front/back of the insurance card(s). You may skip this section if copy is included.

Type of health insurance ○ Commercial ○ Government ○ No insurance (skip this section)

Primary insurance name ●

Policy # ● | Group #

Policy holder name

Insurance phone

Secondary insurance name

Policy # | Group #

Policy holder name

Insurance phone

● *Required fields*

Prescriber information

Prescriber first name ● | Prescriber last name ●

NPI ● | Facility name ●

Facility address 1 ● | Facility address 2

City ● | State ● | ZIP code ●

Primary contact name ● *(First name & last name)*

Primary phone ● | Primary fax ●

Title/role | Primary email

Household information (optional)

We are requesting this information so that we can help determine a patient's eligibility for receiving medication at no cost.

Total # of people in patient's household | Annual household income $

Reason for patient assistance/medication at no cost

○ Uninsured ○ Functionally uninsured/insurance denial ○ Out-of-pocket costs (traditional Medicare only)

Prescriber signature and declaration

I have read and agree to the prescriber declaration on page 3.

● Prescriber signature | ● Print name | ● Date

Patient authorization to disclose information

I have read and agree to the patient authorization to disclose information on page 3.

● Patient/legal representative signature | ● Print name | ● Date

Patient consent and certifications

I have read and agree to the patient consent and certifications on page 4.

● Patient/legal representative signature | ● Print name | ● Date

☐ I have read the text messaging consent on page 4 and expressly consent to receive text messages by or on behalf of **CareASSIST**.

*If one or more parties is unavailable to sign, please submit form and **CareASSIST** will follow up for consent.*
*Please fax completed form to **1-855-411-9689**. A **CareASSIST** Case Manager will be in touch with you in 1-2 business days.*

Prescriber declaration

My signature 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 Sanofi Cares North America for the CareASSIST Patient Assistance Program in response to this application, if any, is exclusively for the patient named on this form. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, to provide the individually identifiable health information on this form to CareASSIST for purposes of researching my patient's health insurance coverage for SARCLISA, assessing their eligibility for financial support programs offered through CareASSIST, and contacting the patient for purposes of program education. It is my professional judgment that SARCLISA 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 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 may revise, change, or terminate any program services at any time without notice to me.

Patient authorization to disclose information

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, 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 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 (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 that may be available to assist me with the costs of my medications.

I further authorize Sanofi 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 may receive from other sources.

I understand that Sanofi 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 (the "Services") or to send the Communications (the "Communications").

I understand and agree that Sanofi 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 in exchange for disclosing My Information to Sanofi and/or for providing me with support services in connection with CareASSIST.

Once My Information has been disclosed to Sanofi, I understand that federal privacy laws may no longer protect it from further disclosure. However, Sanofi 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. For further information regarding these rights, please reference the Sanofi Global Privacy Policy at www.sanofi.com/en/sanofi-us-privacy-policies. 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, 450 Water St., 3rd Floor, Cambridge, MA 02141; Fax: 1-855-411-9689 or by calling **1-833-930-2273**. 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 5 years from the date I sign, subject to applicable law, unless I withdraw it earlier in accordance with the guidance above. I understand that I may request a copy of this authorization.

Patient consent and certifications

I authorize Sanofi, 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: insurance benefits verification, access and reimbursement support, financial assistance, medication and disease education, independent third-party support, and other support services, as well as information or materials related to these services.

If enrolling in the CareASSIST Patient Assistance Program, which provides free medication to eligible patients from Sanofi Cares North America, I certify that the number of people in my household and my household income provided 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. Further, I understand that I am authorizing Sanofi and its affiliates and agents under the Fair Credit Reporting Act to use my date of birth and/or additional demographic information to access and obtain information from my personal credit profile, as well as 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.

If enrolling in 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 SARCLISA will be made in accordance with the Program terms and conditions.

I consent that Sanofi, its affiliates, and agents (such as third-party business partners) collect and use my information for the following purposes: 1) send me information about CareASSIST, my condition, Sanofi products, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys; and 2) use my de-identified information to perform research education, business analytics, marketing studies and other commercial activities. I understand that I may be contacted by Sanofi in the event that I report an adverse event. I understand that the frequency of these messages will vary.

I understand and acknowledge that communications transmitted via unencrypted email or over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner. I understand that I do not have to enroll in CareASSIST or receive the communications described above and that I can still receive Sanofi 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, 450 Water St., 3rd Floor, Cambridge, MA 02141. I also understand that the Services may be revised, changed, or terminated at any time.

Text messaging consent

I acknowledge that by checking the text messaging consent box on page 2, I expressly consent to receive text messages or automated calls from or on behalf of Sanofi at the mobile phone number(s) that I provide. I confirm that I am the subscriber for the mobile phone number(s) provided, and I agree to notify Sanofi promptly if any of my number(s) change in the future. I understand that my wireless service provider's message and data rates may apply to any text messages that I receive from or on behalf of Sanofi at the mobile phone number(s) that I provide. I understand that I can opt out of future text messages at any time. To opt out of receiving texts, I understand that I should reply "STOP" to **833-930-2575**. I understand that my consent to receiving text messages from or on behalf of Sanofi is not required as a condition of purchasing any goods or services from Sanofi or its affiliates.

sanofi