SANOFI Patient Connection™

APPLICATION

PLEASE CHECK ALL THAT APPLY

☐ Patient's HIPAA authorization on file authorizing the release of the patient's identification and insurance information to Sanofi US, and their agents and representatives for BV and Resource Connection purposes

Reimbursement Connection (Benefit Verification [BV])

☐ BV only **(Complete sections 1-3)** (No signatures required)

☐ BV and Patient Assistance (If no coverage is found, prescriber and patient signature required) **(Complete sections 1-3, 5)**

☐ **Patient Assistance Connection**
No cost medication program, prescriber and patient signature required **(Complete sections 1-3, 5)**
SANOFI Foundation for North America

☐ **Resource Connection**
Additional patient resources **(Complete sections 1-4)**

1. PATIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____ Gender: ☐M ☐F

Address:_____ City:_____ State:_____ Zip Code:_____

Phone #:_____ Date of Birth:_____ Social Security #:_____ No Insurance? ☐

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

2. TREATMENT AND PRESCRIBING INFORMATION *(see instructions on page 3 for available products)*

For Lantus® and/or Apidra®, please indicate vials or SoloSTAR® pens

Drug:		ICD/Dx:		Rx:		Qty:		Refills:	
Drug:		ICD/Dx:		Rx:		Qty:		Refills:	
Drug:		ICD/Dx:		Rx:		Qty:		Refills:	

3. PRESCRIBER INFORMATION

Prescriber Name:_____ Prescriber Type:_____ State where Licensed:_____

State License #:_____ NPI #:_____ Tax ID #:_____ DEA #:_____

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:_____

**Sanofi product must be shipped to the signing prescriber's office or hospital address authorized by the prescriber and not to a 3rd party.*

Primary Contact Name:_____ Title/Role:_____

Primary Phone #:_____ Primary Fax #:_____ Primary Email:_____

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I certify that the Sanofi product is medically necessary for this patient and that I am authorized under State law to prescribe and dispense the requested medication. I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification, medical and insurance information to Sanofi US and/or The Sanofi Foundation for North America and their agents and representatives. I understand that any information provided is for the sole use of the Program to verify my patient's insurance coverage, to assess, if applicable, patient's eligibility for participation in the patient assistance program and to otherwise administer the Sanofi Patient Connection program and related services. I understand that I am under no obligation to prescribe any Sanofi product and that I have not received nor will I receive any benefit from Sanofi or their agents or representatives for prescribing a Sanofi product. The facility address noted above in Section 3 is my office or hospital address. My signature certifies that any 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, nor will payment be sought from any payer, patient or other source for product received from the Program.

SIGN HERE _____ _____ _____

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

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4. RESOURCE CONNECTION

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: $_____

Income Verification: Sanofi Patient Connection and its authorized third party agents will 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. Sanofi Patient Connection and its authorized third party agents reserve the right to ask for additional documents and information at any time.

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*)

- ☐ HIPAA consent checked
- ☐ The following must be completed as needed: Dosage, Diagnosis Code, State License Number, Insurance Details
- ☐ Signatures of prescriber and patient (required for Patient Assistance Connection only)

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PRODUCT SELECTION (*please enter desired product in Section 2 for all services)*

- Adacel® (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine adsorbed)
- Apidra® (insulin glulisine [rDNA origin] injection)
- 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 Diptheria 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)]
- Toujeo® (insulin glargine [rDNA origin] injection, 300 units/mL)
- Zaltrap® (ziv-aflibercept)

PATIENT ASSISTANCE CONNECTION ELIGIBILITY REQUIREMENTS

- An application must be submitted for each patient.
- Patient must be a U.S. citizen or resident and be under the care of a licensed healthcare provider authorized to prescribe, dispense and administer medicine in the U.S. (State License Number is required in Section 3).
- Patient must have no insurance coverage or not have access to the prescribed product or treatment via their insurance.
- If a patient has Medicare Part D coverage they can be assessed for patient assistance eligibility by meeting these criteria:
  - Not be eligible for Low Income Subsidy (LIS)
  - Not have coverage for a generic equivalent product
  - Have an out-of-pocket (OOP) total drug spend of 5% of their annual income
- If a patient appears to be eligible for Medicaid they will be required to provide documentation of Medicaid denial before being assessed for patient assistance eligibility.
- Patient must meet the following financial criteria:
  - Annual household income of ≤250% of the current Federal Poverty Level* for all non-Oncology/non-Hematology products
  - Annual household income of ≤500% of the current Federal Poverty Level* for all Oncology and Hematology products
- If applying for Drug Replacement (Lovenox, Oncology and Hematology products only), a copy of the claim, denial, flow sheet(s) and drug dispensing log (with patient name, date of service, product NDC/Lot#, total dosage) must be submitted.
- For Vaccines, patient must be 19 years of age or older (except for IMOVAX RABIES and IMOGAM RABIES HT).

**To assess current Federal Poverty Level details, visit: http://aspe.hhs.gov.*

SANOFI Foundation for North America

FORM SUBMISSION OPTIONS

Secure Provider Portal
www.visitspconline.com

Fax
1.888.847.1797

U.S. Mail

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