SANOFI Patient Connection™

P: 1.800.982.8292 · F: 1.888.847.1797 · www.visitspconline.com
P.O. Box 222138 · Charlotte, NC · 28222-2138

SYNVISC 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]) Determines insurance coverage and options **(Complete sections 1-4)**	☐ **Patient Assistance Connection** No cost medication program, prescriber and patient signature required **(Complete sections 1-4, 6)**	☐ **Resource Connection** Additional patient resources **(Complete sections 1, 2, 4, and 5)**

1. PATIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____ Gender: ☐ M ☐ F
Address:_____ City:_____ State:_____ Zip Code:_____
Cell Phone #:_____ Phone #:_____ Date of Birth:_____ Social Security #:_____

Primary Insurance:		Secondary Insurance:	
Insurance Phone #:		Insurance Phone #:	
Medical Policy #:	Group #:	Medical Policy #:	Group #:
Policy Holder Name:	DOB:	Policy Holder Name:	DOB:
Pharmacy:		Pharmacy:	
Pharmacy Phone #:		Pharmacy Phone #:	
Pharmacy Policy #:	Rx BIN #:	Pharmacy Policy #:	Rx BIN #:

2. DIAGNOSIS AND PRESCRIBING INFORMATION

☐ M17.0 ☐ M17.10 ☐ M17.11 ☐ M17.12 ☐ M17.2 ☐ M17.30 ☐ M17.31 ☐ M17.32 ☐ M17.4 ☐ M17.5 ☐ M17.9 ☐ Other:_____

Please see page 3 for code explanations.

☐ SYNVISC ONE HYLAN G-F 20 8mg/ml (1) 6ml prefilled syringe	☐ SYNVISC HYLAN G-F 20 8mg/ml (3) 2ml prefilled syringes
Inject 1 Synvisc-One syringe into the: ☐ Left knee ☐ Right knee ☐ Bilateral Date needed: Qty kits:	Inject 1 Synvisc Syringe weekly for 3 weeks into the: ☐ Left knee ☐ Right knee ☐ Bilateral Date needed: Qty kits:

Has the patient had any sodium hyaluronate drug treatments in the past? ☐ Yes ☐ No
If yes, has it been less than 6 months since the last sodium hyaluronate injection for the SAME knee? ☐ Yes ☐ No
If yes, last injection date:_____ Site of last injection: ☐ Left knee ☐ Right knee ☐ Bilateral

3. BUY AND BILL OR SPP TRIAGE SERVICE

1. If both options are available, indicate your preference: ☐ Buy and Bill ☐ *Specialty Pharmacy **(prescriber's signature required below)**
2. If SPP is the only option, do you want your Rx to be triaged to the Specialty Pharmacy? ☐ *Yes **(prescriber's signature required)** ☐ No

SPC will conduct a complete benefit verification for your patient. If SPP is selected, kindly advise your patient to settle their copay with the pharmacy as soon as possible to avoid delays in treatment; as product will only be shipped after their copay has been received.
**The Program will triage the prescription to the most cost-effective specialty pharmacy in order to dispense Synvisc to the above named patient. If there are multiple options at the same cost to the patient, Synvisc Connection will select which specialty pharmacy to contact via a rotational basis across the program. State law may require the pharmacy to contact the prescriber directly.*

4. PRESCRIBER INFORMATION

Prescriber Name:_____ Prescriber Type:_____ State where Licensed: _____
State License #:_____ NPI #:_____ Tax ID#:_____ DEA #:_____
Treating Physician Name (if different from prescriber):_____ State where Licensed: _____
State License #:_____ NPI #:_____ Tax ID#:_____ DEA #:_____
Facility Name:_____ Facility Type: ☐ Physician Office ☐ Hospital Outpatient
Facility Address:_____ City:_____ State:_____ Zip Code:_____
Additional shipping instructions or address, if different from facility address above: _____
Primary Contact Name:_____ Title/Role:_____ Primary Phone #:_____
Primary Fax #:_____ Preferred Contact Method (check all that apply): ☐ Phone ☐ Fax ☐ Portal Secure Message

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. 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 4 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
ONLY REQUIRED FOR SPP TRIAGE AND/OR PATIENT ASSISTANCE CONNECTION

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5. 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 ☐ Co-pay Programs

☐ Nutritional Supplements (groceries, food banks, etc.) ☐ Medical Supplies (knee supports, walkers, chair lifts, 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.

6. 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
☐ Insurance Details
☐ Diagnosis Code checked
☐ Prescriber signature (required for SPP Triage and/or Patient Assistance Connection only)
☐ Patient signature (required for Patient Assistance Connection only)

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

SYNVISC ONE® HYLAN G-F 20

SYNVISC® HYLAN G-F 20

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 4).
- Patient must have no insurance coverage or not have access to the prescribed product or treatment via their insurance.
- Patient must meet the following financial criteria:
  - Annual household income of ≤ 250% of the current Federal Poverty Level*

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

ICD-10 CODE EXPLANATIONS

M17.0 (Bilateral primary osteoarthritis of knee)	**M17.31** (Unilateral post-traumatic osteoarthritis, right knee)
M17.10 (Unilateral primary osteoarthritis, unspecified knee)	**M17.32** (Unilateral post-traumatic osteoarthritis, left knee)
M17.11 (Unilateral primary osteoarthritis, right knee)	**M17.4** (Other bilateral secondary osteoarthritis of knee)
M17.12 (Unilateral primary osteoarthritis, left knee)	**M17.5** (Other unilateral secondary osteoarthritis of knee)
M17.2 (Bilateral post-traumatic osteoarthritis of knee)	**M17.9** (Osteoarthritis of knee, unspecified)
M17.30 (Unilateral post-traumatic osteoarthritis, unspecified knee)	

FORM SUBMISSION OPTIONS

Secure Provider Portal
www.visitspconline.com

Fax
1.888.847.1797

U.S. Mail

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