CareConnectPSS® Co-Pay Program Application

Enzyme Replacement Therapies

Please complete **both pages** of this application, sign and fax to 1-855-627-8435. You can also mail it to: CareConnectPSS Co-Pay Program, P.O. Box 221736, Charlotte, NC 28222-1736

Contact Information

I am (please check one):

○ Applying for myself

○ Applying as the patient's custodial parent or legal guardian (explain): ______________________

____

Patient's First Name: ____________________ Last Name: ______________________________

Street Address: ____

City: ____________________ State: ____________________ Zip Code: ________________

Date of Birth: ____________________ Email Address: ____________________________

Phone Number: ________________________ Sanofi Genzyme Product: ____________________

Gender: ○ Male ○ Female

1. Are you a resident of the United States or a U.S. Territory? ○ Yes ○ No
2. Do you have commercial or private insurance? ○ Yes ○ No
3. Are you enrolled in Sanofi Genzyme's Charitable Access Program? ○ Yes ○ No
4. Are your prescriptions paid for in part or in full under any state or federally funded programs, including but not limited to Medicare, Medicare Part D, Medigap, Veterans Affairs, Department of Defense, or TRICARE? ○ Yes ○ No
5. Are you in the military, or the dependent of someone that is active or retired military? ○ Yes ○ No
6. Are your prescriptions paid in part or in full by the military? ○ Yes ○ No

If you answered yes to questions 4, 5, or 6, then you are not eligible for co-pay assistance. You may contact your CareConnectPSS Case Manager at 1-800-745-4447, option 3, with any questions.

Health Insurance Information

Primary Insurance Carrier: ____

Policy ID Number: ________________________ Plan Type (ie, HMO, PPO): ________________

Telephone Number: ____

Secondary Insurance Carrier (if applicable): _____________________________________

Physician Information

Please fill in the following information about the doctor prescribing enzyme replacement therapy for you.

Physician First Name: ____________________ Physician Last Name: ____________________

Street Address: ____

City: ____________________ State: ____________________ Zip Code: ________________

Phone Number: ____

Fax Number: ________________________ Physician's Specialty (if known): ________________

Physician Office Contact (Name and Number): ____________________________________

Infusion Site Name, Address, and Phone Number (if home infused, please provide the name of the Home Health Agency): ____

____

For questions regarding the completion of this application form, please call your CareConnectPSS Case Manager at 1-800-745-4447, option 3.

careconnect PSS®
Personalized Support Services

Authorization to Share Health Information

By signing this Authorization to Share Health Information ("Authorization"), I authorize my healthcare providers, health insurers, and the pharmacy that dispenses my Sanofi Genzyme medication (collectively, the "Parties") to disclose to Genzyme Corporation (together with its affiliates, including Sanofi, "Sanofi Genzyme") and its third-party business partners and other agents ("Agents") my health information, including information related to my medical condition and treatment, insurance coverage and claims, and prescription (the "Information"), for the purposes of coordinating my enrollment and participation in the CareConnectPSS Co-Pay Program (Co-Pay Program). Some of the arrangements between Sanofi Genzyme and other Parties for the disclosure of my Information to Sanofi Genzyme may involve payment to those parties. Once my information has been disclosed to a third party, I understand that federal privacy laws may no longer protect it from further disclosure. However, Sanofi Genzyme and its Agents agree to use and disclose my Information only as allowed by me in this Authorization or as otherwise allowed by law. I understand that I may refuse to sign this Authorization, and a refusal to sign this Authorization will not affect my ability to obtain medical care, insurance coverage, or access to therapy. However, if I do not sign this Authorization, I will not be able to enroll in the Co-Pay Program. This Authorization shall remain in effect through my participation in the Co-Pay Program unless and until I cancel it. I may cancel this Authorization at any time by writing to CareConnectPSS at 50 Binney Street, Cambridge, MA 02142 or send an email to copay.program@sanofi.com, and include my name and address. I understand that canceling this Authorization will end my participation in the Co-Pay Program and will not affect any use or disclosure of the Information made before my request is received and processed.

By signing below, I certify that I have read and understand the Authorization to Share Health Information and agree to its terms.

Name (Print): ______________________________

Signature: ______________________________ **Date:** ______________

Program Authorization

By signing below, I am enrolling in the CareConnectPSS Co-Pay Program (Co-Pay Program), provided by Genzyme Corporation (together with its affiliates, including Sanofi, "Sanofi Genzyme") and its third-party business partners and other agents ("Agents"). By enrolling in the Co-Pay Program, I acknowledge and understand that (1) the Co-Pay Program will pay 100% of my eligible out-of-pocket drug costs for my covered drug up to the Co-Pay Program maximum, and (2) I will be responsible for paying any amounts over the Co-Pay Program maximum. By signing this Co-Pay Program Authorization, I authorize Sanofi Genzyme and its Agents to (i) use and share with my healthcare providers, pharmacies and insurers information about me for the purpose of coordinating my enrollment and participation in the Co-Pay Program; (ii) contact me by mail, telephone and/or email in connection with the Co-Pay Program; and (iii) de-identify my information and use it in performing business analytics and marketing studies or for other commercial purposes. I understand a representative from Sanofi Genzyme may contact me for follow-up on any adverse event I may report regarding a Sanofi Product. I understand that I do not have to enroll in the Co-Pay Program and that if I choose not to enroll I can still receive my medication as prescribed by my physician. I may opt out of the Co-Pay Program at any time by writing to CareConnectPSS at 50 Binney Street, Cambridge, MA 02142 or copay.program@sanofi.com, and include my name and address. In accordance with state law, infusion related costs are not covered for commercially insured individuals residing in MA, MI, or RI. Charitable Access Program patients residing in these states are eligible for the Co-Pay Program. The Co-Pay Program runs from January 1 through December 31 of the current calendar year. I understand that I may need to re-enroll each year in order to confirm continued eligibility.

By signing below, I certify that I have read and understand the Program Authorization and agree to its terms.

Name (Print): ______________________________

Signature: ______________________________ **Date:** ______________

©2020 Genzyme Corporation. All rights reserved. CareConnectPSS, Sanofi and Genzyme are registered in the U.S. Patent and Trademark Office. MAT-US-2018449-v2.0-11/2020

SANOFI GENZYME