CareConnectPSS® Co-Pay Program Application

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: M _______ F _______

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, my health insurers, and the pharmacy that dispenses my Sanofi Genzyme medication to disclose to Genzyme Corporation (together with its affiliates, including Sanofi, "Sanofi Genzyme") and its third party business partners, vendors and other agents ("Agents") my health information, including but not limited to 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 (the "Program"). 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. I further understand that a refusal to sign this Authorization will not affect my ability to obtain medical care, insurance coverage, or access to health benefits, including my access to therapy. However, if I do not sign this Authorization, I understand that I will not be able to enroll in the Program. I understand that this Authorization shall remain in effect through my participation in the 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 by sending an email to copay.program@sanofi.com. I understand that canceling this Authorization will end my participation in the 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 Name)

Signature: ____________________ Date: ____________

PLEASE SIGN BOTH

Program Authorization

I am enrolling the CareConnectPSS Co-Pay Program (the "Program"), provided by Genzyme Corporation (together with its affiliates, including Sanofi, "Sanofi Genzyme") and its third-party business partners, vendors, and other agents ("Agents"). By enrolling in the Program, I acknowledge and understand that (1) the Program will pay 100% of my eligible enzyme replacement out-of-pocket drug costs and certain infusion-related costs (mixing and administration of the drug as well as infusion supplies such as saline, IV tubing, etc.) up to the program maximum, and (2) I will be responsible for paying any amounts over the program maximum.

By signing this Program Authorization, I authorize Sanofi Genzyme and its Agents to use and share with my healthcare providers, specialty pharmacies, and insurers information about me for the purpose of coordinating my enrollment and participation in the Program. I also authorize Sanofi Genzyme and its Agents to contact me by mail, telephone, and/or email in connection with the Program and to inform me of available assistance programs, treatment and therapies, and insurance-related information. I further authorize Sanofi Genzyme and its Agents to de-identify my health information and use it in performing clinical research, patient and community education, business analytics, marketing studies, or for other commercial purposes.

I understand that I do not have to enroll in the 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 Program at any time by writing to the CareConnectPSS Co-Pay Program at 50 Binney Street, Cambridge, MA 02142, or by sending an email to copay.program@sanofi.com.

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

Name: ____________________ (Print Name)

Signature: ____________________ Date: ____________

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