CareConnectPSS® Co-Pay Program Application

Enzyme Replacement Therapies

sanofi

Please complete both pages of this application, sign and fax to 1-800-750-9839.
You can also mail it to:
CareConnectPSS Co-Pay Program
P.O. Box 52040, Phoenix, AZ 85072-2040

Contact Information

I am (please check one):

☐ Applying for myself ☐ Applying as the patient's custodial parent or legal guardian **(explain):**

_____

Sanofi Product: _____

Patient's First Name: _____ **Last Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

DOB (MM/DD/YYYY): _____ **Email:** _____

Phone: _____ **Gender:** ☐ **Male** ☐ **Female**

1. Do you live in the United States or a U.S. Territory? ☐ **Yes** ☐ **No**
2. Do you have commercial or private insurance? ☐ **Yes** ☐ **No**
3. 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**
4. Are you in the military, or the dependent of someone that is active or retired military? ☐ **Yes** ☐ **No**
5. Are your prescriptions paid in part or in full by the military? ☐ **Yes** ☐ **No**

If you answered yes to questions 3, 4, or 5, then you are not eligible for co-pay assistance. Please contact your CareConnectPSS Case Manager at 1-800-745-7447, option 3, with any questions.

Health Insurance Information

Primary Insurance Carrier: _____

Policy ID Number: _____ **Plan Type (ie, HMO, PPO):** _____

Phone: _____

Secondary Insurance Carrier (if applicable): _____

Prescription Benefit Information

Prescription Drug Plan Name: _____

Rx Group Number: _____ **Rx Bin Number:** _____

ID Number: _____ **Phone (on PBM card):** _____

Physician Information

Please fill in the following information about the doctor prescribing your Enzyme Replacement Therapy:

Physician First Name: _____ **Physician Last Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Fax:** _____

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):

_____

_____

careconnect PSS® Personalized Support Services

CareConnectPSS® ERT Co-Pay Program

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 medication (collectively, the "Parties") to disclose to Sanofi (together with its affiliates, "Sanofi") 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 and other Parties for the disclosure of my Information to Sanofi 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 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 Attn: Case Management, 450 Water Street, Cambridge, MA 0214 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 Sanofi (together with its affiliates, "Sanofi") 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 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 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 Attn: Case Management, 450 Water Street, Cambridge, MA 02141; 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 or RI. 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:** _____

For questions regarding the completion of this application form or about the Co-Pay Program, please call the CareConnectPSS Co-Pay Program at 1-855-448-6520.

CareConnectPSS Co-Pay Program has an annual maximum of $15,000. Not valid for prescriptions paid, in whole or in part, by Medicaid, Medicare, VA, DOD, TRICARE, or other federal or state programs including any state pharmaceutical assistance programs. No claim for reimbursement of any out-of-pocket covered by the Co-Pay Program may be submitted to any third party payer, whether public or private, including but not limited to my insurance, my Flexible Spending account (FSA), or Health Savings Account (HSA), or any other type of medical savings account. This program is not valid where prohibited by law, taxed or restricted. Sanofi reserves the right to rescind, revoke, terminate, or amend this offer, eligibility, and terms of use at any time without notice. Any savings provided by the program may vary depending on patients' out-of-pocket costs. Patients will receive all program details upon registration.

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