Cablivi® caplacizumab-yhdp Injection 11 mg

HemAssist™ Patient Support for CABLIVI Enrollment Form

Complete the entire form and fax to 800-914-0694
Call 1-833-723-5463 Monday – Friday 8 AM to 7 PM ET

www.CABLIVI.com

Patient to Fill Out

1 PATIENT INFORMATION (REQUIRED)

PATIENT FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ LAST 4 DIGITS OF SSN _____ ☐ MALE ☐ FEMALE ☐ OTHER

STREET ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

CELL PHONE ( ) _____ OTHER PHONE ( ) _____ ☐ OK TO LEAVE A MESSAGE

EMAIL ADDRESS _____

CAREGIVER (IF APPLICABLE) _____ PHONE ( ) _____

PATIENT'S PRIMARY LANGUAGE ☐ ENGLISH ☐ OTHER IF OTHER, PLEASE SPECIFY _____

PATIENT AUTHORIZATIONS

REQUIRED:
I have read and agree to the Patient Authorization to Use and Disclose Health Information included in Section 6.

PATIENT SIGN

_____ _____
PATIENT SIGNATURE DATE
(1 of 2) Patient signature/Legal representative

_____
Printed name if signed by legal representative

OPTIONAL:
☐ Check this box to agree to receive Sanofi Communications outlined in Section 7.

REQUIRED:
I have read and agree to the Patient Certifications included in Section 7.

PATIENT SIGN

_____ _____
PATIENT SIGNATURE DATE
(2 of 2) Patient signature/Legal representative

_____
Representative relationship to patient

2 HOUSEHOLD INCOME

REQUIRED FOR THE HEMASSIST FOR CABLIVI PATIENT ASSISTANCE PROGRAM.

NUMBER OF HOUSEHOLD MEMBERS _____
(Including patient)

CURRENT ANNUAL HOUSEHOLD INCOME $ _____
(Please include: after-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income.)

Please refer to Section 7, Patient Certifications, for additional information about the HemAssist for CABLIVI financial assistance programs.

Verification of income is required for participation in the HemAssist for CABLIVI Patient Assistance Programs. Acceptable documentation includes a W-2, IRS-1040, or a recent paystub.

3 INSURANCE INFORMATION

PLEASE ATTACH COPIES (FRONT AND BACK) OF ALL AVAILABLE INSURANCE AND PRESCRIPTION CARDS. ☐ **NO INSURANCE**

PRIMARY MEDICAL INSURANCE NAME _____

INSURANCE PHONE ( ) _____ POLICY ID # _____

GROUP # _____ POLICYHOLDER NAME (FIRST/LAST) _____

EMPLOYER OF POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

PRESCRIPTION DRUG INSURANCE NAME (IF DIFFERENT) _____

INSURANCE PHONE ( ) _____

POLICY ID # _____ GROUP # _____

RXBIN # _____ RXPCN # _____

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4 PRESCRIBER INFORMATION (REQUIRED)—Specialty pharmacy will need to contact the provider prior to dispensing

PRESCRIBER NAME _____ PRESCRIBER FACILITY NAME _____

OFFICE CONTACT NAME _____

SPECIALTY _____ OFFICE CONTACT EMAIL _____

ADDRESS _____ PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ FAX ( ) _____

NPI _____ TAX ID _____ STATE LICENSE _____

HOSPITAL ADMISSION DATE _____

COMPLETE THE BELOW IF THE PATIENT IS HOSPITALIZED (REQUIRED FOR DISCHARGE PLANNING AND SHIPPING COORDINATION).

HOSPITAL NAME _____ HOSPITAL CONTACT NAME _____

ADDRESS _____ HOSPITAL CONTACT EMAIL _____

CITY _____ STATE _____ ZIP _____ PHONE ( ) _____ FAX ( ) _____

HOSPITAL CONTACT PHONE ( ) _____ HOSPITAL CONTACT FAX ( ) _____

5 PRESCRIPTION INFORMATION (REQUIRED FOR PATIENT SERVICES TO SEND PRESCRIPTION TO THE SPECIALTY PHARMACY)

PATIENT NAME _____ DATE OF BIRTH _____

DIAGNOSIS _____

☐ ICD-10 CODE M31.1 ☐ Other

DATE OF INITIAL CABLIVI INFUSION _____

DATE PEX THERAPY INITIATED _____

IMMUNOSUPPRESSANT THERAPY _____

☐ Hospital Pharmacy to Dispense (if approved pharmacy)

☐ Specialty Pharmacy to Dispense

Rx: CABLIVI (caplacizumab)

SIG: Administer 11 mg subcutaneously daily

☐ Qty: 30 Day Refill: ☐ 28 Day Extension

☐ Qty: Other _____ Refill: ☐ Qty: Other _____

Potential Hospital Discharge Date _____

Prescriber to Fill Out

My signature certifies that the person named on this form is my patient; that the information provided on this application, to the best of my knowledge, is complete and accurate; and that therapy with CABLIVI is medically necessary.

I acknowledge that I have obtained authorization to release the patient's personal health information and the information on this form and any prescription to Genzyme Corporation (together with its parents and affiliates, "Sanofi") and its third-party business partners, vendors, and other agents ("Agents") for the purpose of providing product support services ("the Programs"). I further certify that any service provided by Sanofi on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use any Sanofi product or service for anyone, and my decision to prescribe CABLIVI was based solely on my determination of medical necessity. I understand that my information may be used by Sanofi to manage and improve the Programs, to communicate with me about my experience with the Programs, and/or to send patient materials relating to the Programs. With respect to any free product provided to the patient listed above, I understand that provision of the product is not contingent on any purchase obligations. I also understand that no claim for reimbursement will be submitted to Medicare, Medicaid, or any third-party payer for medication received free of charge under the Program, or for related medical procedures and services; nor should the free product be sold, traded, or distributed for sale. I authorize Sanofi or its affiliated companies or subcontractors, including in-network specialty pharmacies, through the HemAssist for CABLIVI Program ("Program") to forward this prescription electronically, by facsimile, or by mail to the relevant in-network pharmacy for the above-named patient. In addition, I certify and warrant the following: This request has been prepared exclusively by me or my office. I understand that HemAssist for CABLIVI may revise, change, or terminate any program services at any time without notice to me. I will notify the Specialty Pharmacy immediately if CABLIVI is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. I authorize Sanofi as my designated agent and on behalf of my patient to (1) forward the above service request form and furnish any information on this form to the insurer of the above-named patient and (2) forward the above prescription, by fax or other modes of delivery, to dispensing pharmacy. I agree to assist in efforts to secure access to CABLIVI for my patient in the event of a coverage delay.

The prescriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

_____ _____ _____

PRESCRIBER SIGNATURE REQUIRED—**NO STAMPS** PRINTED NAME DATE

_____ _____ ( ) _____

NPI TAX ID PHONE

CA, MA, NC & PR: INTERCHANGE IS MANDATED UNLESS PRESCRIBER WRITES THE WORDS "**NO SUBSTITUTION**". _____

ATTN: NEW YORK AND IOWA PROVIDERS, PLEASE SUBMIT ELECTRONIC PRESCRIPTION.

sanofi

Patient: Please read the following carefully, then date and sign where indicated in Section 1 on page 1.

6 AUTHORIZATION FOR RELEASE AND USE OF HEALTH INFORMATION

By signing this Authorization to Release Health Information ("Authorization"), I authorize my health care providers (including my pharmacies), and my health plans and insurers [and their contractors] (collectively, the "Parties") to disclose to Genzyme Corporation including its parents, affiliates, and its third party business partners, vendors, and other agents (collectively, "Sanofi") information about my disease, treatment, insurance coverage, and payment for my therapy (together with the information I have provided on this Enrollment Form and may provide in the future, "my Information") for the purposes of Sanofi providing me with patient support services and sending me communications that I have agreed to receive elsewhere in this Enrollment Form.

The Parties and Sanofi may use and disclose my Information for the purposes of providing certain support services I agree to in this Enrollment Form, including, but not limited to: (1) determining if I am eligible to participate in the HemAssist for CABLIVI Program ("the Program"); (2) to manage and improve the Program; (3) to communicate with me about my experience with the Program; (4) to send materials relating to the Program; (5) investigating my health insurance coverage; (6) operating and administering the Program; and (7) contacting me for follow-up on any adverse event I may disclose regarding a Sanofi product. I further authorize Sanofi to de-identify my health information and use it in performing research, education, business analytics, and marketing studies, or for other commercial purposes, including linkage with other de-identified information Sanofi may receive from other sources.

I understand that once my information has been disclosed to Sanofi, federal privacy laws may no longer protect the information from further disclosure, but that Sanofi intends to use and disclose my information only in accordance with this Authorization or as otherwise allowed by law. I understand that Sanofi may provide my specialty pharmacy with payment to obtain,use or disclose my information. I understand that my personal health information may be used for communications between Sanofi and me which may be considered marketing. Specialty Pharmacies may receive remuneration in exchange for disclosing my information and/or for providing me with support services in connection with the HemAssist for CABLIVI Program. You may have certain rights under applicable data privacy laws regarding your personal information, including the right to access your personal information held by Sanofi. For further information regarding these rights, please reference our Global Privacy Policy at www.sanofi.com/en/ourresponsibility/ sanofi-global-privacy-policy.

I understand that I may refuse to sign this Authorization and that a refusal to sign will not affect my ability to obtain medical care, insurance coverage, or access to health benefits, including access to therapy. However, if I do not sign this Authorization, Sanofi cannot provide me with support services. Authorization expires 5 years from the date I signed unless subject to applicable law unless or until I withdraw (take back) this Authorization before then. I understand that I may withdraw this Authorization at any time by sending a written notice that includes my name, address, and phone number, to Sanofi, ATTN: RBD Patient Services, 450 Water St, Cambridge, MA 02141, or by emailing RBDPatientSolutions@sanofi.com. Withdrawal of this Authorization will end further reliance on this Authorization (and my participation in the Program) but it will not affect any use or disclosure of my Information before my notice of withdrawal is received and processed.

I certify that I have read and understand the Authorization for the Release and Use of Health Information and agree to its terms. I understand that I am entitled to a copy of this Authorization upon request.

Patient: Please read the following carefully, then date and sign where indicated in Section 1 on page 1.

7 PATIENT CERTIFICATIONS

I authorize Sanofi to provide me with various therapy support services for which I am eligible, which may include but are not limited to: online support, patient education compliance and persistency support, insurance benefits verification and reimbursement support (if requested), coverage and financial assistance support (if requested), and such other support services as may be added in the future, as well as any information or materials related to such support services. I acknowledge and understand that Sanofi cannot provide me with medical advice, and I will direct all treatment-related questions to my healthcare professional.

I understand and agree that Sanofi may contact me about such services and information by mail, e-mail, telephone call, fax, or other means at the telephone numbers, email, and mailing addresses I provide. 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 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 calling the Case Management team at 833.723.5463, emailing RBDPatientSolutions@sanofi.com, or sending a written notice that includes my name, address, and phone number, to Sanofi, ATTN: RBD Patient Services, 450 Water St, Cambridge, MA 02140. Sanofi reserves the right to modify or terminate any or all support services at any time without notice.

If enrolling in the HemAssist Copay Program-CABLIVI* (the "Copay Program"), I understand that my Copay Card information will be sent to my designated specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or copayment for CABLIVI will be made in accordance with the Copay Program terms and conditions.

*Not valid if the patient is utilizing a state or federally-funded health insurance program such as Medicare (including Medicare Part D), Medicaid, Medigap, VA, DoD, TRICARE®, state pharmaceutical assistance program, etc. to pay in part or in full for your CABLIVI prescription.

I also agree that Sanofi may verify my eligibility for the HemAssist for CABLIVI Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional financial, insurance, and/or medical information. I authorize Sanofi under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that, upon request, Sanofi will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize Sanofi to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the HemAssist for CABLIVI Program eligibility determination process, if applicable. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. If approved for the HemAssist for CABLIVI Program, I will not seek to have the value of any medication provided to me under this program counted toward my true-out-of-pocket (TrOOP) cost for prescription drugs for my Medicare Part D Plan. Continuation in the HemAssist for CABLIVI Program is conditioned upon timely verification of income. In addition, I agree to notify Sanofi HemAssist for CABLIVI immediately if my insurance status or my income changes. Sanofi reserves the right to review assistance requests based on patient needs and to change program guidelines or terminate the program at any time without notification.

SANOFI COMMUNICATIONS CONSENT

I agree that Sanofi and its agents (such as third-party business partners) can contact me by mail, email, fax and/or telephone, including calls and text messages (if consent is provided to receive text messages), and send me information about rare blood disorders and relevant Sanofi products, promotions, services, and research studies, ask my opinion about such information and topics, including through market research and disease-related surveys, and share the information I provide with one another to perform these activities, and to de-identify it for use in performing research, education, business analytics, marketing studies, and other commercial purposes. If I agree to receive text messages, I understand that text messaging rates may apply. Your information will not be sold to any third party but may be provided to regulatory authorities if required. You may have certain rights under applicable data privacy laws regarding your personal information, including the right to access your personal information held by Sanofi. For further information regarding these rights, please reference our Global Privacy Policy. You may opt out of continued receipt of such communications at any time by e-mailing RBDPatientSolutions@sanofi.com.

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