CareASSIST®
Patient Support by Sanofi

Enrollment Form

Fax: 1-855-411-9689
Phone: 1-833-WE+CARE (1-833-930-2273)
Mon–Fri, 9 AM–8 PM ET

The CareASSIST Patient Support Program offers personalized support to eligible patients prescribed the following Sanofi medications.
Completed forms can be submitted by fax, mail, or online at SanofiCareASSIST.com.
Questions? Speak with one of our Care Managers by dialing 1-833-WE+CARE.

Treatment Selection: ◯ ELITEK® (rasburicase) ◯ JEVTANA® (cabazitaxel) injection ◯ SARCLISA® (isatuximab-irfc)

Section 1 Support Requested (Check all that apply)

◯ **Access and Reimbursement**
- ◯ Prior authorization assistance
- ◯ Claims/appeals assistance

◯ **Financial Assistance**
- ◯ CareASSIST Copay Program
- ◯ CareASSIST Patient Assistance Program (PAP)

◯ **Helpful Resources**
Connecting patients to resources they may need to support their treatment journey

Section 2 Patient Information

First Name | MI | Last Name | Gender ◯ M ◯ F | Date of Birth

Address | City | State | ZIP Code

Home Phone | ◯ Preferred Phone | OK to Leave Detailed Message? ◯ Yes ◯ No | Email

Cell Phone | ◯ Preferred Phone | OK to Leave Detailed Message? ◯ Yes ◯ No

Patient's Preferred Language (if not English)

Alternate Contact/Caregiver Information (optional)

First Name | Last Name | Phone # ◯ Home

Relationship to Patient | Email | ◯ Mobile

Does the patient consent for the program to contact the caregiver ◯ Yes ◯ No

Patient Consent and Certification (See Section 8 on page 3)

I have read and agree to the patient consent and certifications included in Section 8.

SIGN HERE

Patient/Legal Representative Signature | Date

Patient Authorization (See Section 9 on page 4)

I have read and agree to the patient authorization included in Section 9.

SIGN HERE

Patient/Legal Representative Signature | Date

Print Name/Relationship to Patient (If applicable)

◯ **I have read the Text Messaging Consent in Section 8 and expressly consent to receive text messages by or on behalf of CareASSIST.**

Section 3 Insurance Information

Is the patient insured? ◯ Yes (please provide insurance information) ◯ No (move to next section)

Primary Insurance Name	Secondary Insurance Name
Policy #	Policy #
Policy Holder Name	Policy Holder Name
Relationship to Patient	Relationship to Patient
Insurance Phone #	Insurance Phone #
Group #	Group #

Section 4 Patient Household Information (Only required if CareASSIST Patient Assistance Program [PAP] Support box above is chosen)

Total # of people in the household

Annual household income $

Please complete and return all pages to CareASSIST by fax to 1-855-411-9689
or by mail to 450 Water St., 3rd Floor, Cambridge, MA 02141.

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Section 5 Prescriber Information

Prescriber Name | Prescriber Type | State Where Licensed

State License # | NPI # | Tax ID #

Physician Name (if different from prescriber) | State Where Licensed | State License #

Facility Name | Facility Type ◯ Prescriber Office/Clinic ◯ Hospital Outpatient ◯ Hospital Inpatient

Facility Address | City | State | ZIP Code

Primary Contact Name | Title/Role

Primary Phone # | Primary Fax # | Primary Email

Section 6 Medication Information

ICD-10 Diagnosis Codes section must be completed prior to form submission.

6a

Product	ICD-10 Diagnosis Codes
◯ ELITEK® (rasburicase)*	Write in code _____
◯ JEVTANA® (cabazitaxel) injection*	Write in code _____
◯ SARCLISA® (isatuximab-irfc)*	Write in code _____

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Prescription Information		
Dosage	Quantity (no. of doses)	No. of refills
Administer _____ mg as an IV infusion over 30 minutes daily for up to 5 days	__/5 (5 max)	N/A
Administer _____ mg as an IV infusion over 1 hour every 3 weeks	__/1 (1 max)	____ PRN refills for one year
Administer _____ mg as an IV infusion according to the rates specified in section 2.5 of the full Prescribing Information	__/2 (2 max)	____ PRN refills for one year

(FOR SARCLISA) If obtaining through specialty pharmacy, check which specialty pharmacy commercial prescription was sent to:

◯ CVS Specialty ◯ Biologics

Previous treatments (include start/end dates)

***Please see full Prescribing Information, including Boxed WARNINGS. Full US Prescribing Information for all Sanofi CareASSIST-supported products can be accessed at www.sanofi.us/en/products-and-resources/prescription-products.**
The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

Section 7 Prescriber Signature and Declaration (Please note that prescriber signatures cannot be stamped)

SIGN HERE

Prescriber Signature (required - no stamps) | Printed Name | Date

Please complete and return all pages to CareASSIST by fax to 1-855-411-9689
or by mail to 450 Water St., 3rd Floor, Cambridge, MA 02141.

Patient Name | Date of Birth

Section 7 Prescriber Declaration (Continued from page 2)

My signature on page 2 certifies that the person named on this form is my patient, the information provided on this application is complete and accurate to the best of my knowledge, and the medication received free of charge from Sanofi Cares North America for the CareASSIST Patient Assistance Program in response to this application, if any, is exclusively for the patient named on this form. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, to provide the individually identifiable health information on this form to CareASSIST for purposes of researching my patient's health insurance coverage for the medication in Section 6, assessing their eligibility for financial support programs offered through CareASSIST, and contacting the patient for purposes of program education. It is my professional judgment that the medication selected in Section 6 is medically necessary for the patient named on this form. I hereby certify that no medication received free of charge under the CareASSIST Patient Assistance Program shall be offered for sale, trade, or barter, and that no claim for reimbursement will be submitted to Medicare, Medicaid, or any third-party payer for medication received free of charge under the CareASSIST Patient Assistance Program. I consent to Sanofi and its affiliates and agents contacting me by fax, phone, mail, or email to confirm receipt of this medication and/or to provide additional information about this medication or CareASSIST. I understand that Sanofi may revise, change, or terminate any program services at any time without notice to me.

Section 8 Patient Consent and Certifications

I hereby authorize Sanofi and its affiliates and agents to provide services to me under the CareASSIST Patient Support Program, as described in this form and as may be supplemented in the future. Such services may include: determining if I am eligible to enroll in and/or receive services from CareASSIST, including access and reimbursement assistance services, patient assistance programs, and resource services; investigating my health insurance coverage benefits; providing information on prior authorizations and appeals of denied claims for coverage/reimbursement; referring me to, or determining my eligibility for, other programs and/or alternate sources of funding; and providing information on other independent support services that may be available to me (together, the "Services").

If enrolling in the CareASSIST Patient Assistance Program, which provides free medication to eligible patients from Sanofi Cares North America, I certify that the number of people in my household and my household income provided on the Income Verification step are true and accurate to the best of my knowledge. To qualify for the CareASSIST Patient Assistance Program, I understand that I must meet certain income and other eligibility requirements. Further, I understand that I am authorizing Sanofi and its affiliates and agents under the Fair Credit Reporting Act to use my date of birth and/or additional demographic information to access and obtain information from my personal credit profile, as well as use information derived from public and other sources, to estimate my income in conjunction with the eligibility determination process. Continuation in the program is conditional upon timely verification of income. If requested, I agree to provide CareASSIST with proof of income within thirty (30) days of the request. I agree to immediately inform CareASSIST and my doctor/healthcare provider if my income or insurance status changes during the course of my participation in the CareASSIST Patient Assistance Program.

If enrolling in the CareASSIST Copay Program, I agree to my enrollment in such program if confirmed as eligible. I understand that copay information will be sent to my physician or the designated specialty pharmacy, and any assistance with my applicable cost-sharing or copayment for each medication selected by my prescriber will be made in accordance with the Program terms and conditions.

I authorize Sanofi and its affiliates and agents to contact me by mail, telephone (including calls made with an automatic telephone dialing system or a prerecorded voice), or email with information about CareASSIST, Sanofi products, my condition, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I understand that I may be contacted by Sanofi in the event that I report an adverse event. I understand that the frequency of these messages will vary.

I understand and acknowledge that communications transmitted via unencrypted email or over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner. I understand that I do not have to enroll in CareASSIST or receive the communications described above (the "Communications") and that I can still receive Sanofi products as prescribed by my physician. I may opt out of receiving Communications and/or individual Services, including the CareASSIST Patient Assistance Program, or opt out of CareASSIST entirely at any time by notifying a CareASSIST representative by telephone at **1-833-WE+CARE** (1-833-930-2273) or by sending a letter to CareASSIST, 450 Water St., 3rd Floor, Cambridge, MA 02141. I also understand that the Services may be revised, changed, or terminated at any time.

Text Messaging Consent:

I acknowledge that by checking the Text Messaging Consent Box on page 1, I expressly consent to receive text messages or automated calls from or on behalf of Sanofi at the mobile phone number(s) that I provide.

I confirm that I am the subscriber for the mobile phone number(s) provided, and I agree to notify Sanofi promptly if any of my number(s) change in the future. I understand that my wireless service provider's message and data rates may apply to any text messages that I receive from or on behalf of Sanofi at the mobile phone number(s) that I provide. I understand that I can opt out of future text messages at any time. To opt out of receiving texts, I understand that I should reply "STOP" to 833-930-2575.

I understand that my consent to receiving text messages from or on behalf of Sanofi is not required as a condition of purchasing any goods or services from Sanofi or its affiliates.

Patient Name | Date of Birth

Section 9 Patient Authorization to Disclose Information

I authorize my healthcare providers and staff; my health insurer, health plan, or programs that provide me healthcare benefits (together, "Health Insurers"); and any specialty pharmacies that dispense my medication to disclose to Sanofi, and its affiliates and agents, health information about me, including patient-related information provided throughout this form and related to my medical condition, treatment with prescribed Sanofi therapies, health insurance coverage, claims, prescriptions, and referral to and enrollment in the CareASSIST Patient Support Program and Copay Program (together, "My Information"). My healthcare providers, Health Insurers, specialty pharmacies, and Sanofi (including its agents and affiliates) may use and disclose My Information for the purposes of providing certain support services, including: to determine if I am eligible to enroll in and/or receive services from CareASSIST, including access and reimbursement assistance services, patient financial assistance programs, and resource services; for the operation and administration of CareASSIST; to investigate my health insurance coverage benefits; to assist with prior authorization for coverage/reimbursement; to assist with the status of appeals of denied claims for coverage/reimbursement; and to refer me to, or to determine eligibility for, other programs and/or alternate sources of funding—such as Medicaid, healthcare exchanges, Medigap, state pharmaceutical assistance programs (SPAPs), and charitable foundations— that may be available to assist me with the costs of my medications.

I further authorize Sanofi and its affiliates and agents 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 Sanofi and its affiliates and agents may share My Information, including identifiable health information, among themselves in order to de-identify it for these purposes and as needed to perform the Services or to send the Communications.

I understand and agree that Sanofi and its affiliates and agents may use My Information for these purposes and may share My Information with my doctors, specialty pharmacies, and Health Insurers.

I understand and agree that my healthcare providers, Health Insurers, and specialty pharmacies may receive remuneration from Sanofi in exchange for disclosing My Information to Sanofi and/or for providing me with support services in connection with CareASSIST.

Once My Information has been disclosed to Sanofi, I understand that federal privacy laws may no longer protect it from further disclosure. However, Sanofi agrees to protect My Information by using and disclosing it only for the purposes authorized in this authorization or as otherwise required by law.

I understand that I may have certain rights under applicable data privacy laws regarding My Information, including the right to access My Information held by Sanofi. For further information regarding these rights, please reference the Sanofi Global Privacy Policy at www.sanofi.com/en/our-responsibility/sanofi-global-privacy-policy. I understand that if I decline to sign this authorization, I will not be able to participate in CareASSIST, but it otherwise will not affect my eligibility to obtain medical treatment, my ability to seek financial assistance from other sources, or my insurance enrollment or eligibility for insurance coverage.

Furthermore, I understand that I may withdraw (take back) this authorization at any time by mailing or faxing a written request to CareASSIST, 450 Water St., 3rd Floor, Cambridge, MA 02141; Fax: 1-855-411-9689. Withdrawal of this authorization will end further uses and disclosures of My Information by the parties identified in this authorization except to the extent those uses and disclosures have been made in reliance upon this authorization prior to my request to withdraw this authorization.

This authorization expires 18 months from the date support is last provided under any CareASSIST program, subject to applicable law, unless I withdraw it earlier. I understand that I may request a copy of this authorization.

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or by mail to 450 Water St., 3rd Floor, Cambridge, MA 02141.