Cablivi
caplacizumab-yhdp
Injection 11 mg

CABLIVI PATIENT SOLUTIONS ENROLLMENT FORM

Print and fax completed enrollments forms to 800-914-0694
All 3 pages must be received to process enrollment

Phone: 855-724-7222
Fax: 800-914-0694
Web: www.cablivi.com

Support Requested (check all that apply)

☐ COPAY ASSISTANCE*	☐ PATIENT ASSISTANCE PROGRAM	☐ SUPPLEMENTAL ADMINISTRATION TRAINING
Up to $25,000 in out of pocket copay or coinsurance costs related to Cablivi prescription ***(Sections 1-5 & 8 must be completed)***	Access to Cablivi at no cost for eligible patients ***(Sections 1-4, 6 & 8 must be completed)***	In home Nurse administration training ***(Sections 1-4, 7 & 8 must be completed)***

Other eligibility requirements may apply. Sanofi reserves the right to modify or discontinue the programs at any time. Please visit www.cablivi.com for more information.

*Those with federal and state government insurance, such as Medicare, Medicaid, or TRICARE are not eligible. TRICARE is a registered trademark of the Department of Defense (DoD), Defense Health Agency (DHA). All rights reserved.

Patient to Fill Out

Section 1: Patient Information

PATIENT NAME (FIRST, MI, LAST):		PHONE: ( )	☐PREFERRED #	☐VOICEMAIL
ADDRESS:		MOBILE PHONE: ( )	☐PREFERRED #	☐VOICEMAIL
CITY:	STATE:	ZIP	EMAIL	
DOB (mm/dd/yyyy)	GENDER: ☐ Male ☐ Female	PREFERRED PATIENT LANGUAGE (IF NOT ENGLISH)		

1.	Are you a resident of the United States or US Territory?	☐ YES	☐ NO
2.	Do you have Commercial or Private Insurance?	☐ YES	☐ NO
3.	Are your prescriptions paid for in part of 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

Section 2. Insurance Information

****Please attach copies (front and back) of all available insurance and prescriptions cards*** No Insurance? ☐

PRIMARY MEDICAL INSURANCE NAME	**PRIMARY RX** INSURANCE NAME (IF DIFFERENT)
INSURANCE PHONE #: ( )	RX INSURANCE PHONE: ( )
POLICY ID #	POLICY ID #
GROUP #	GROUP #
POLICY HOLDER NAME (FIRST / LAST)	RXBIN #
RELATIONSHIP TO PATIENT	RXPCN #

Required for the Cablivi Patient Assistance Program
Current annual gross income: $_____ Number of household members (including patient): _____
(Please include: before-tax wages, pension, interest / dividends, Social Security benefits and any other sources of income.)

Prescriber to Fill Out

Section 3: Prescriber Information

PRESCRIBER NAME			PRESCRIBER FACILITY NAME	
PRESCRIBER NPI	GROUP TAX ID #		OFFICE CONTACT NAME	
SPECIALTY			OFFICE CONTACT EMAIL	
ADDRESS			PHONE: ( )	
CITY	STATE	ZIP	FAX:( )	
HOSPITAL ADMISSION DATE:			***COMPLETE BELOW IF THE PATIENT IS HOSPITALIZED AT A DIFFERENT LOCATION THAN THE PRESCRIBER***	
HOSPITAL NAME			HOSPITAL CONTACT NAME	
ADDRESS			HOSPITAL CONTRACT EMAIL	
CITY	STATE	ZIP	PHONE: ( )	FAX: ( )

Section 4: Treatment and Prescription Information: *Only fill out Section 4 if prescription is being filled by Biologics Specialty Pharmacy.*

Diagnosis: _____
ICD-10 Code:

Rx: CABLIVI (caplacizumab)
SIG: Administer 11 mg. subcutaneously daily
Qty _____ Refill _____

DATE OF INITIAL CABLIVI INFUSION ___ / _____ / _____

Potential Hospital Discharge Date _____ / _____ / _____

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 AFFILIATES, INCLUDING SANOFI, "SANOFI GENZYME") AND ITS THIRD PARTY BUSINESS PARTNERS, VENDORS AND OTHER AGENTS ("AGENTS"), FOR THE PURPOSE OF PROVIDING PRODUCT SUPPORT SERVICES. I FURTHER CERTIFY THAT ANY SERVICE PROVIDED BY SANOFI GENZYME 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 GENZYME PRODUCT OR SERVICE FOR ANYONE, AND MY DECISION TO PRESCRIBE CABLIVI WAS BASED SOLELY ON MY DETERMINATION OF MEDICAL NECESSITY. I UNDERSTAND THAT FREE PRODUCT IS NOT CONTINGENT ON ANY PURCHASE OBLIGATIONS. I ALSO UNDERSTAND THAT NO FREE PRODUCT MAY BE SUBMITTED FOR REIMBURSEMENT TO ANY PAYER, INCLUDING MEDICARE AND MEDICAID; NOR SHOULD IT BE SOLD, TRADED, OR DISTRIBUTED FOR SALE. I WILL NOTIFY BIOLOGICS IMMEDIATELY IF CABLIVI IS NO LONGER MEDICALLY NECESSARY FOR THIS PATIENT'S TREATMENT OR IF MY PATIENT'S INSURANCE STATUS CHANGES. I AUTHORIZE SANOFI GENZYME 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 MODE OF DELIVERY, TO BIOLOGICS SPECIALTY PHARMACY.

THE PRESCRIBER IS TO COMPLY WITH HIS/HER 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.

SIGN HERE

Prescriber Signature Required – no stamps	Printed Name	Date

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☐ 5. CABLIVI COPAY / COINSURANCE ASSISTANCE PROGRAM: PATIENT AUTHORIZATION

I am enrolling in the Cablivi Co-Pay / Coinsurance Assistance Program (the "Copay Program"), provided by Sanofi Genzyme and its third party business partners, vendors and other agents ("Agents") . By enrolling in the Copay Program, I acknowledge and understand that (1) I am responsible for paying any out of pocket amounts over the program maximum, (2) in-patient medication is not covered by the program -- only product dispensed to my home is eligible for copay/coinsurance assistance, and (3) the Program will pay 100% of my Cablivi copay and coinsurance expenses up to the program maximum. I confirm that my personal and insurance information in Sections 1 and 2 of this form are accurately completed and that I am not a beneficiary of a federal or state healthcare program. I will notify Cablivi Patient Solutions immediately if my insurance status changes.

By signing this Copay Program Authorization, I authorize Sanofi Genzyme and its Agents to use and share information about me with my healthcare providers, Biologics specialty pharmacy and my insurance company for the purpose of coordinating my enrollment and participation in the Copay Program. I also authorize Sanofi Genzyme and its Agents to contact me by mail, telephone, or e-mail in connection with the Copay Program and to inform me of available assistance programs, treatment and therapies, and insurance-related information.

I 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 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 Copay 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 Copay Program at any time by writing to the Cablivi Patient Solutions at 11800 Weston Parkway, NC 27513 or by sending an email to cablivipatientsolutions@mckesson.com

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

Patient or Legal Representative	**Printed Name**	**Date**

Release of Health Information (page 3 of this application) must also be signed to complete enrollment

☐ 6. PATIENT ASSISTANCE PROGRAM: PATIENT AUTHORIZATION

Sanofi Genzyme's Patient Assistance Program ("PAP") provides drug at no cost to patients who are uninsured or underinsured and meet all eligibility requirements of the Cablivi PAP program. This is not a replacement program; applications must be submitted prior to CABLIVI use in the home or outpatient setting.

I certify that all of the information provided in this application, including information about my income, is complete and accurate. I acknowledge that no free product received via the PAP program may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor may be sold, traded, or distributed for sale. I understand that this program is not meant to induce a physician to use or prescribe CABLIVI. I also understand that the program provides drug only. I will notify the Cablivi Patient Solutions immediately if my insurance status changes. Sanofi Genzyme reserves the right to review assistance requests based on patient need and to change program guidelines or terminate the program at any time without notification.

By signing this Patient Assistance Program Authorization, I authorize Sanofi Genzyme and its Agents to use and share information about me with my healthcare providers, Biologics specialty pharmacy and my insurance company for the purpose of coordinating my enrollment and participation in the PAP Program. I also authorize Sanofi Genzyme and its Agents to contact me by mail, telephone, or e-mail in connection with the PAP Program and to inform me of available assistance programs, treatment and therapies, and insurance-related information.

I 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 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 Cablivi PAP 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 Cablivi Patient Solutions at 11800 Weston Parkway, NC 27513 or by sending an email to: cablivipatientsolutions@mckesson.com.

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

Patient or Legal Representative	**Printed Name**	**Date**

Release of Health Information (page 3 of this application) must also be signed to complete enrollment

☐ 7. CABLIVI SUPPLEMENTAL ADMINISTRATION TRAINING PROGRAM: PATIENT AUTHORIZATION

I am enrolling in the Cablivi Supplemental Administration Training Program ("Administration Training Program"), provided by Sanofi Genzyme and its third party business partners, vendors and other agents ("Agents") . By enrolling in the Administration Training Program, I acknowledge and understand that the Administration Training Program (1) is provided at no-cost to patients with a valid Cablivi prescription and (2) will result in a registered nurse coming to my home to train me or my designated agent on the proper administration of Cablivi. I further acknowledge and understand that the Program Nurse cannot administer Cablivi or provide me with medical advice. I will direct all treatment related questions to my healthcare professional.

By signing this Cablivi Supplemental Administration Training Program Authorization, I authorize Sanofi Genzyme and its Agents to use and share information about me with my healthcare providers, Biologics specialty pharmacy and my insurance company for the purpose of coordinating my enrollment and participation in the Administration Training Program. I also authorize Sanofi Genzyme and its Agents to contact me by mail, telephone, or e-mail in connection with the Administration Training Program and to inform me of available assistance programs, treatment and therapies, and insurance-related information.

I 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 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 Administration Training 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 Cablivi Patient Solutions at 11800 Weston Parkway, NC 27513 or by sending an email to cablivipatientsolutions@mckesson.com.

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

Patient or Legal Representative	**Printed Name**	**Date**

Release of Health Information (page 3 of this application) must also be signed to complete enrollment

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8. AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

By signing this Authorization to Release Health Information ("Authorization"), I authorize my Providers, Payers, Caregivers, and Distributors (collectively, the "Parties") to disclose to Sanofi Genzyme and its Agents information about my disease, treatment, insurance coverage and payment for my therapy ("my Information") for the purposes of providing the Services and allowing Sanofi Genzyme to send the communications for the programs I have authorized through this form. These services include but are not limited to: (1) to determining if I am eligible to participate in Cablivi Patient Solutions programs (the "Program"), (2) investigating my health insurance coverage for Cablivi, and (3) operating and administering the Program. Once my Information has been disclosed to Sanofi Genzyme and its Agents, 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 my pharmacy may get payments from Sanofi Genzyme for my information. 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 may refuse to sign this Authorization, that I may refuse to disclose all or some of my information, 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 Genzyme cannot provide me with services. This Authorization shall remain in effect throughout my participation in the Program unless and until I cancel it; provided, however, that if I am a Minnesota resident, this Authorization is effective for one year. I may cancel this Authorization at any time by writing to the Cablivi Patient Solutions at 11800 Weston Parkway, Cary, NC 27513, or by sending an email to cablivipatientsolutions@mckesson.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 Release Health Information and agree to its terms. I understand that I am entitled to a copy of this Authorization upon request.

Patient or Legal Representative	**Printed Name**	**Date**

I authorize Sanofi Genzyme and its Agents to discuss my Information with the following designated individual(s) in connection with the Services (optional):

NAME :	**RELATIONSHIP TO PATIENT:**
EMAIL:	**PHONE:**
NAME:	**PATIENT REPRESENTATIVE:**
EMAIL:	**PHONE:**

9. AGREE TO RECEIVE RELEVANT SANOFI GENZYME MARKETING COMMUNICATIONS (OPTIONAL)

Sanofi Genzyme would like to send you additional information about our products and financial assistance programs.

We will not sell or transfer your personal data to any unrelated third party for marketing purposes without your express permission. We may share such personal data with regulatory authorities, if required, or contact you to conduct market research.

I authorize Sanofi Genzyme, and companies working with Sanofi Genzyme, to contact me by mail, e-mail, and/or telephone to provide me with the information I requested and other related information and services or programs that Sanofi Genzyme offers or sponsors, or other topics of interest. I understand that I am not required to provide this consent as a condition of purchasing any property, goods, or services from Sanofi Genzyme. I also understand that I may participate in the Cablivi Patient Solutions Program if I do not sign this optional marketing authorization. To learn more about how your information is used or if you decide that you no longer want to receive information about Sanofi Genzyme's products and services, please contact Cablivi Patient solutions at cablivipatientsolutions@mckesson.com.

☐ Check here if you are interested in sharing your story and/or experience with others. By checking this box, I understand that a representative from Sanofi Genzyme may contact me to discuss my experience with aTTP and/or Cablivi.

Patient or Legal Representative	**Printed Name**	**Date**

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