Cablivi
caplacizumab-yhdp
Injection 11 mg

CABLIVI Patient Solutions Enrollment Form

Print and fax completed forms to 800-914-0694. Phone: 855-724-7222 www.cablivihcp.com
Call Us 8 AM-8 PM EST Monday-Friday

Sanofi reserves the right to modify or terminate these programs at any time without notice.

PATIENT EDUCATION SERVICES

Services may be available to provide you with disease and product education and supplemental administration training.

FINANCIAL ASSISTANCE PROGRAMS

CABLIVI financial assistance programs may be available to help you with the cost of treatment. Access to CABLIVI at no cost may be available to eligible patients who are uninsured or underinsured. Co-pay assistance may be available for out-of-pocket co-pay or co-insurance costs related to CABLIVI prescription.*

*Not valid for CABLIVI prescriptions covered by or submitted for reimbursement under Medicare, Medicaid, VA, DoD, Tricare, or similar federal or state programs including any state pharmaceutical assistance programs. Not valid where prohibited by law. Savings may vary depending on patient's out-of-pocket costs. Upon registration, patient will receive all program details.

To request Patient Education Services, complete Sections 1-6.
To request Financial Assistance Programs, complete Sections 1-5 and 7.

Patient to Fill Out

1 PATIENT INFORMATION

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 ( ) _____ EMAIL ADDRESS _____
PREFERRED METHOD ☐ PHONE ☐ EMAIL PREFERRED TIME ☐ MORNING ☐ AFTERNOON ☐ EVENING
CAREGIVER (IF APPLICABLE) _____
PATIENT'S PRIMARY LANGUAGE ☐ ENGLISH ☐ OTHER IF OTHER, PLEASE SPECIFY _____

2 INSURANCE INFORMATION

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

PRIMARY MEDICAL INSURANCE NAME _____
INSURANCE PHONE # _____ POLICY ID # _____
GROUP # _____ POLICYHOLDER NAME (FIRST/LAST) _____
EMPLOYER OF POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____
CURRENT ADDRESS _____ CITY _____ STATE _____ ZIP _____
PRESCRIPTION DRUG INSURANCE NAME (IF DIFFERENT) _____
INSURANCE PHONE _____
POLICY ID # _____ GROUP # _____
RXBIN# _____ RXPCN # _____

SECONDARY MEDICAL INSURANCE NAME _____
INSURANCE PHONE # _____ POLICY ID # _____
GROUP # _____ POLICYHOLDER NAME (FIRST/LAST) _____

REQUIRED FOR THE CABLIVI FINANCIAL ASSISTANCE PROGRAM FOR UNINSURED OR UNDERINSURED PATIENTS.
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

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 THE BELOW IF THE PATIENT IS HOSPITALIZED AT A DIFFERENT LOCATION THAN THE PRESCRIBER.
HOSPITAL NAME _____ HOSPITAL CONTACT NAME _____
ADDRESS _____ HOSPITAL CONTACT EMAIL _____
CITY _____ STATE _____ ZIP _____ PHONE ( ) _____ FAX ( ) _____
HOSPITAL CASE MANAGER NAME _____ HOSPITAL CASE MANAGER EMAIL _____
HOSPITAL CASE MANAGER PHONE _____

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4 PRESCRIPTION INFORMATION

Prescriber to Fill Out

PATIENT NAME _____ DATE OF BIRTH _____

DIAGNOSIS _____
ICD-10 CODE _____
DATE OF INITIAL CABLIVI INFUSION _____

Rx: CABLIVI (caplacizumab)

SIG: Administer 11 mg subcutaneously daily

☐ Qty: 30 Day Refill: _____

☐ Qty Other: _____ 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 parents and affiliates, "Sanofi Genzyme") and its third-party business partners, vendors, and other agents ("Agents") (together with Sanofi Genzyme, "Sanofi"), 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 Genzyme 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 will notify Biologics 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 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.

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

5 AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

Patient to Fill Out

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 (together with its parents and affiliates, "Sanofi Genzyme"), and its third-party business partners, vendors, and other agents ("Agents") (together with Sanofi Genzyme, "Sanofi") information about my disease, treatment, insurance coverage, and payment for my therapy ("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 (including its Agents) 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 CABLIVI Patient Solutions Program ("the Program"); (2) to manage and improve the Program; (3) to communicate with me about my experience with the Program; (4) 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 report regarding a Sanofi Genzyme 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 pharmacy with payment in order to obtain my Information. 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. I understand that this Authorization expires 2 years from the date I signed unless subject to applicable law unless or until I withdraw (take back) this Authorization before then.

Further, 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 Genzyme, ATT: Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by fax to 1-855-398-7634. Withdrawal of this Authorization will end further reliance on this Authorization (and my participation in the Program) but it will not invalidate reliance on the Authorization to use or disclose my Information before my notice of withdrawal is received and processed.

By signing below, I certify that I have read and understand the Authorization to Release Personal 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 SIGNATURE REQUIRED PRINTED NAME DATE

RELATIONSHIP TO PATIENT EMAIL

6 PATIENT EDUCATION & SUPPORT SERVICES AUTHORIZATION

Patient to Fill Out

I authorize Sanofi to provide me with various therapy support services for which I am eligible, which may include but is not limited to: online support, patient education services, and compliance and persistency services, as well as any information or materials related to such 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 text message to the cell phone number I provided on this enrollment form (including autodialed; message and data rates may apply), 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 sending a written notice that includes my name, address, and phone number, to Sanofi Genzyme, ATT: Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by sending a fax to 1-855-398-7634. Sanofi Genzyme reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

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

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE REQUIRED | PRINTED NAME | DATE

Release of Personal Health Information (Section 5 on page 2 of this application) must also be signed to complete enrollment.

7 FINANCIAL ASSISTANCE PROGRAMS PATIENT AUTHORIZATION (CO-PAYMENT, PATIENT ASSISTANCE PROGRAM)

Patient to Fill Out

I confirm that my personal and insurance information in this form are accurately completed.

If applying for the CABLIVI® (caplacizumab) Co-pay/Coinsurance Assistance Program (the "Co-pay 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; (3) the Co-pay Program does not cover costs associated with administration of therapy such as office visits, non–product-specific expenses related to supplies, procedures, or physician-related services, or other professional services; (4) the Co-pay Program will pay 100% of my eligible co-pay, coinsurance, and other out-of-pocket expenses up to the program maximum; and (5) patients who start utilizing state or federal government-funded health coverage during their enrollment period will no longer be eligible. I certify that I am not a beneficiary of a federal or state healthcare program and that CABLIVI is not covered by and will not be submitted for reimbursement under any state or federal program, including but not limited to Medicaid, Medicare, VA, DOD, TRICARE, or any state pharmaceutical assistance program. I will notify Sanofi Genzyme Rare Blood Disorders Patient Services immediately if my insurance status changes. By signing this Co-pay Program Authorization, I authorize Sanofi to use and share information about me with my healthcare providers, specialty pharmacy providers, and my insurance company for the purpose of coordinating my enrollment and participation in the Co-pay Program.

If applying for the Cablivi Patient Assistance Program ("PAP"), which provides drug at no cost to patients who are uninsured or underinsured and meet all eligibility requirements of the PAP, I understand that this is not a replacement program. I certify that all of the information provided in this application, including information about my household income and the number of people in my household, is complete and accurate. Sanofi Genzyme Rare Blood Disorders Patient Services may use my date of birth and/or additional demographic information as needed to access my credit information and may 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 Sanofi with proof of income within thirty (30) days of the request. I acknowledge that no free product received via the PAP may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor may be sold, traded, or distributed for sale, and I certify that I will not submit any claims for any free product received via the PAP. I also certify that I will not count the free product received via the paper towards my true out-of-pocket costs for any insurance plan I may have. I understand that this program is not meant to induce a physician to use or prescribe CABLIVI. I will notify Sanofi Genzyme Rare Blood Disorders Patient Services immediately if my income or 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.

I also authorize Sanofi Genzyme and its Agents to contact me by mail, telephone, text message to the cell phone number I provided on this enrollment form (including autodialed; message and data rates may apply), or email in connection with Financial Assistance Programs and to inform me of available assistance programs, treatment and therapies, and insurance-related information. 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 Financial Assistance Programs 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 Sanofi Genzyme, ATT: 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by sending an email to: RBDpatientsolutions@sanofi.com. Sanofi Genzyme reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

By signing below, I certify that I have read and understand the Financial Assistance Programs Patient Authorization and agree to its terms. Release of Personal Health Information (Section 5 on page 2 of this application) must also be signed to complete enrollment.

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE REQUIRED | PRINTED NAME | DATE

8 AGREE TO RECEIVE RELEVANT SANOFI GENZYME MARKETING COMMUNICATIONS (OPTIONAL)

Patient to Fill Out

Sanofi would like to contact you to provide additional information about our products and financial assistance programs or contact you to conduct market research. You must be eighteen (18) years or older to enroll. Your information will not be sold to any third party but may be provided to regulatory authorities if required.

I authorize Sanofi to contact me by mail, email, fax, and/or telephone, including calls and text messages (message and data rates may apply) made using an automatic telephone dialing system (autodialer) or a prerecorded voice, at the telephone number(s) provided on this enrollment form 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 and that I may participate in the Programs if I do not sign this optional marketing authorization. My Personal Data will be processed and stored in electronic databases controlled by or on behalf of Sanofi Genzyme. 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 send a letter to Sanofi Genzyme, RBD Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142.

☐ 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 SIGNATURE REQUIRED | PRINTED NAME | DATE

Release of Personal Health Information (Section 5 on page 2 of this application) must also be signed to opt into receiving marketing communications.