Claims Department
PO Box 845
Stevens Point, WI 54481-0047
Toll Free: 1-800-295-4010

AIG Claims, Inc. is a wholly owned subsidiary of AIG and provides claims administration for the Group Policy provided with the Sanofi Promise Warranty Program.

Sanofi Promise Warranty Program for CABLIVI® (caplacizumab-yhdp)
PHYSICIAN ATTESTATION FORM
(TO BE COMPLETED BY TREATING PHYSICIAN)

Please email the **completed** forms to SanofiPromise@aig.com or fax to 1-715-342-2405 or mail to PO Box 845, Stevens Point, WI 54481-0047. For questions, please call 1-800-295-4010, Monday–Friday, 8 am–8 pm ET. The information you provide will be used by Sanofi's third-party administrator, AIG Claims, Inc. and/or its affiliates (collectively, "AIG") to determine eligibility and administer warranty claims. For details about how AIG collects and uses personal information submitted via this form, please visit https://www.aig.com/privacy-policy.

Prescribing Physician

Prescribing Physician Name (First/MI/Last): _____

NPI #: _____

State License #: _____

E-mail: _____

Office Phone: _____

Site of Care Information

Hospital Name: _____

Address, City, State Zip: _____

FAX # : _____

YES	NO	
		Did patient have any other condition prior or concurrent to aTTP/iTTP that could have resulted in non-response?
		Did patient receive CABLIVI in the 60 days prior to hospital admission?
		Was CABLIVI administered (dose and duration) in accordance with the FDA label (Prescribing Information)?

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I certify that:

☐	Any causes for the drop in platelet count other than aTTP/iTTP pathophysiology have been ruled out
☐	Patient discontinued the treatment once they became a non-responder per treating provider's clinical judgment and not in order to obtain warranty payment.

Healthcare Provider Consent

I understand that completing this attestation form does not guarantee that a warranty remedy will be provided to the hospital. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. I understand that the information provided on this attestation form is subject to random audits and verification. I understand that my information may be provided to Sanofi for its administration and compliance of the Warranty Program. Sanofi may change or cancel this program at any time. Should Sanofi change or cancel the program, it will continue to honor valid warranty claims related to qualifying doses of CABLIVI dispensed during the period in which the program remained in effect.

Telephone Consumer Protection Act (TCPA) Attestation

I also give my permission to receive calls related to these services from Sanofi, Warranty Program, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided regarding the purposes described above. I consent to providing my information to Sanofi as it relates to the Warranty Program.

I declare that, to the best of my knowledge and belief, all of the information provided in support of this claim is complete, true and accurate. I understand that if I made or shall make any false or fraudulent statements or withhold material facts relating to this claim, this could result in Hospital disqualification of the benefits.

Acknowledgement of State Fraud Laws:

For residents of all states except those states and territories noted below:

WARNING: Any person who knowingly and with the intent to injure, defraud, deceive any insurance company or other person, who files a statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to criminal prosecution, civil penalties and forfeiture of insurance benefits.

For residents of WASHINGTON D.C., MAINE, TENNESSEE, VIRGINIA and WASHINGTON: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

For residents of ARKANSAS, KENTUCKY, LOUISIANA, NEW MEXICO, PENNSYLVANIA, RHODE ISLAND, TEXAS and WEST VIRGINIA:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under this title.

ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false,

incomplete, or misleading facts or information to a policyholder or Card Member for the purpose of defrauding or attempting to defraud the policyholder or Card Member with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE, IDAHO and OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

INDIANA: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Physician Signature: _____

Date of Signature: _____

Physician Email Address: _____