Cerdelga® (eliglustat) capsules for oral use Co-Pay Assistance Program Application

Please complete all pages of this application, sign and fax to 855-627-8435.
Alternatively, you can mail it to: CareConnectPSS® Co-Pay Assistance Program, P.O. Box 221736, Charlotte, NC 28222-1736

YOUR CONTACT INFORMATION

I am (please check one):

☐ Applying for myself ☐ Applying as the patient's custodial parent or legal guardian:

(Explain) _____

Patient's First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Email Address: _____

Gender: M _____ F _____ Phone Number: _____

1. Do you have commercial or private insurance? ☐ YES ☐ NO
2. Do you have prescription drug coverage? ☐ YES ☐ NO
3. Are your prescriptions paid for in part or 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

If you answered yes to questions 3, 4, or 5, then you are not eligible for co-pay assistance. You may contact your CareConnectPSS Case Manager at 800-745-4447, option 3, with any questions.

YOUR HEALTH INSURANCE INFORMATION

Primary Insurance Carrier: _____

Policy ID Number: _____ Plan Type (i.e. HMO, PPO): _____

Telephone Number: _____

Secondary Insurance Carrier (if applicable): _____

YOUR PRESCRIPTION BENEFIT INFORMATION

Your Specialty Pharmacy Name: _____

Rx Grp#: _____ Rx Bin#: _____

ID # : _____ Phone # (on your PBM card) : _____

YOUR PHYSICIAN INFORMATION

Please fill in the following information about the doctor prescribing Cerdelga for you.

Physician First Name: _____ Physician Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Physician's Specialty (if known): _____

Physician Office Contact Person Name and Phone Number: _____

PROGRAM AUTHORIZATION

I am enrolling in the Cerdelga® (eliglustat) Co-Pay Assistance Program (the "Program"), provided by Genzyme Corporation (together with its affiliates, including Sanofi, "Sanofi Genzyme") and its third party business partners and other agents ("Agents"). By enrolling in the Program, I acknowledge and understand that (1) the Program will pay 100% of my eligible out-of-pocket drug costs for Cerdelga up to the Program maximum, and (2) I will be responsible for paying any amounts over the Program maximum.

By signing this Program Authorization, I authorize Genzyme and its Agents to (i) use and share with my healthcare providers, pharmacies and insurers information about me for the purpose of coordinating my enrollment and participation in the Program; (ii) contact me by mail, telephone and/or email in connection with the Program; and (iii) de-identify my information and use it in performing business analytics, marketing studies or for other commercial purposes. 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 writing to CareConnectPSS® at 50 Binney Street, Cambridge, MA 02142 or copay.program@sanofi.com, and including my name and address.

By signing below, I certify that I have read, understand and agree to the terms of the Program Authorization, and I represent that I am (select one):

☐ The applicant and at least 18 years old; or

☐ The patient's legal representative

Name: _____ (Print Name)

Signature: _____ Date: _____

Authorization to Share Health Information

By signing this Authorization to Share Health Information ("Authorization"), I authorize my healthcare providers, health insurers, and the pharmacy that dispenses my Sanofi Genzyme medication (collectively, the "Parties") to disclose to Sanofi Genzyme and its Agents my health information, including information related to my medical condition and treatment, insurance coverage and claims, and prescription (the "Information"), for the purposes of coordinating my enrollment and participation in the Cerdelga Co-Pay Assistance Program. Some of the arrangements between Sanofi Genzyme and other Parties for the disclosure of my Information to Sanofi Genzyme may involve payment to those Parties. Once my information has been disclosed to a third party, 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 I may refuse to sign this Authorization, and a refusal to sign this Authorization will not affect my ability to obtain medical care, insurance coverage, or access to therapy. However, if I do not sign this Authorization, I will not be able to enroll in the Program. This Authorization shall remain in effect through my participation in the Program unless and until I cancel it. I may cancel this Authorization at any time by writing to CareConnectPSS at 50 Binney Street, Cambridge, MA 02142 or copay.program@sanofi.com, and including my name and address. 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 and agree to its terms.

Name: _____ (Print Name)

Signature: _____ Date: _____

SANOFI GENZYME

careconnect PSS® Personalized Support Services