Patient Assistance Program Application
CAPRELSA® (vandetanib) Tablets

Please return completed application by fax

Phone: 800-367-4999 (M-F, 9:00am-6:00pm Eastern Time) Fax: 888-275-8593 Website: www.caprelsa.com

(The patient must complete this application, with assistance from their physician who must sign this form, to be considered for assistance through Patient Assistance Program)

Please complete all applicable sections. This application cannot be processed without applicable signatures.

Sanofi Genzyme's Patient Assistance Program provides drug at no cost to eligible patients who are uninsured or underinsured. If approved, shipment will be coordinated with the requesting physician. This is not a replacement program; applications must be submitted prior to CAPRELSA use. CAPRELSA provided for use by this program is not intended for resale or to be billed to any patient or third party payer, including Medicare and Medicaid. This program is not meant to induce a physician to use or prescribe CAPRELSA. The program provides drug only; patients would need to find alternative means to support other medical costs associated with the use of this medication. Sanofi Genzyme reserves the right to review patient profiles, grant requests based on patient need and to change program guidelines or terminate the program at any time without notification.

PATIENT INFORMATION		
First Name:	Middle Initial: Last Name:	
Date of Birth:	Gender: ❑Male ❑Female	
Contact Name *(if other than patient):*	Contact Phone Number:	Email:
Street Address:		Apt. #:
City:	State:	Zip Code:

MEDICAL INFORMATION
Diagnosis: *Advanced or Metastatic Medullary Thyroid Cancer*
Please Check Appropriate Indication: ❑ Symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease. -OR- ❑ Indolent, asymptomatic or slowly progressing disease only after careful consideration of the treatment related risks of CAPRELSA
❑ ICD-10 Code: C73 ❑ Other

PATIENT ELIGIBILITY		
Is the patient a resident of the United States or a US Territory?	❑Yes	❑No
Does patient have health insurance?	❑Yes	❑No
If patient has health insurance, has coverage for CAPRELSA been denied? (If Yes, please attach copy of denial letter)	❑Yes	❑No

- You must have an annual household income of ≤600% of the current Federal Poverty Level. If you may be eligible for Medicaid, you will be required to provide documentation of Medicaid denial before being assessed for patient assistance eligibility.
- If you are enrolled in Medicare Part D, you may also be eligible based on the income criteria noted above.
- You must have no insurance coverage or, for commercially insured patients, have no access to the prescribed product or treatment via your insurance.

INSURANCE DETAILS (Complete section below OR attach copies of front and back of insurance cards. If no insurance, move to next section.)	
Primary Insurance:	Secondary Insurance:
Policy #: Group #:	Policy #: Group #:
Insurance Company Phone:	Insurance Company Phone:
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Date of Birth:

Patient Assistance Program Application for CAPRELSA (Continued)

Please return completed application by fax

Phone: 800-367-4999 (M — F, 9:00am — 6:00pm Eastern Time) Fax: 888-275-8593 Website: www.caprelsa.com

(Physician must complete application for patient to be considered for assistance through Patient Assistance Program)

Please complete all applicable sections. This application cannot be processed without applicable signatures.

Patient Name:	**DOB:**

PROVIDER and SHIPPING INFORMATION

Prescriber Name:			
NPI #:	DEA#:	Tax ID#:	
Prescriber Specialty: ❑ Oncology	❑ Endocrinology	❑ Surgery	❑ Other:
Facility / Group Name:			
Phone:	Fax:	Email:	
Street Address:			
City:	State:		Zip Code:
Shipping Details *(Check if patient address is the same as listed Patient Information Section)*			
Patient Name:			
Street Address:			
City:	State:		Zip Code:
Phone Number:	Ok to leave a message: ❑ Yes ❑ No	Email:	

PRESCRIPTION FOR CAPRELSA®

Please complete all fields. Illegible Rx will be returned.

Prescriber:			
Medication/Strength:	Directions:	QTY:	Refills: 0 — 1 — 2 — 3 ❑ 1 year
Medication/Strength:	Directions:	QTY:	Refills: 0 — 1 — 2 — 3 ❑ 1 year
PRESCRIBER SIGNATURE:			

CERTIFICATION AND CONSENT (Signatures and Dates Required)

PRESCRIBER

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I certify that CAPRELSA is medically necessary for this patient and that I will be supervising the patient's treatments. I certify that I have obtained from my patient all required written authorizations, in accordance with State and Federal law for the disclosure of the information provided above to Biologics and Sanofi Genzyme for the purposes of assessing patient's eligibility for participation in the Patient Assistance Program, including verifying my patient's insurance coverage, facilitating prior authorization if needed, coordinating shipment of CAPRELSA, or referring patient to other programs or alternate sources of funding or coverage for CAPRELSA. I understand that submitting an application to the Patient Assistance Program does not guarantee that assistance will be obtained. By signing this document, I attest that the financial information I have provided is complete and accurate. If at any time it is deemed necessary to audit the patient's financial information, I will provide supportive documentation to Biologics. I agree that I will not submit claims or otherwise seek payment from any source for product provided through the patient assistance program. I understand that Biologics and Sanofi Genzyme have the right to revise, change, or terminate this Program (and the assistance provided) at any time, without notice.

PRESCRIBER SIGNATURE: _____ **DATE:** _____

PATIENT or PATIENT REPRESENTATIVE: _____

I certify that the information provided is current, complete, and accurate to the best of my knowledge. By signing below, I consent to my participation in the Patient Assistance Program and request that Biologics, Sanofi Genzyme, their affiliated companies, agents, representatives and contractors use the information in this form and any supportive documentation that is provided to support this request to assess my eligibility for participation in the patient assistance program, including verifying my insurance coverage and facilitating prior authorization if needed, and to refer me to, or determine my eligibility for, other programs or alternate sources of funding assistance or coverage that may be available to assist me with the costs of my treatment. I understand that Biologics, Sanofi Genzyme, have the right to revise, change, or terminate this program (and the assistance provided) at any time, without notice.

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT REPRESENTATIVE: _____ **DATE:** _____

RELATION TO PATIENT: _____

Please see full prescribing information for CAPRELSA, including Boxed WARNING, https://products.sanofi.us/caprelsa/caprelsa.pdf, and Medication Guide

Support Services Authorization

I am registering for a Sanofi Genzyme support service (the "Program"), provided by Genzyme Corporation (together with its affiliates, "Sanofi Genzyme"), which offers the following services related to my medical condition ("Disease") and my Sanofi Genzyme therapy ("Therapy") (collectively, the "Services"):

Education: providing educational support and resources about my Disease and its management to me and others who may benefit, which may include periodic communications from Sanofi Genzyme.

Benefits Verification: helping me get access to my Therapy and related services ordered by my Provider, which may include reviewing, verifying and helping me and my Providers understand my insurance benefits.

Reimbursement Support: helping me, and coordinating with my Providers on my behalf, with respect to billing, reimbursement and payment issues related to my Therapy, which may include assisting with the insurance claims process and identifying other potential sources of financial assistance, if necessary.

Distribution of Therapy: coordinating the distribution of my Therapy, which may include identifying the appropriate distribution channel under my insurance plan, facilitating the correct amount of Therapy to be sent to my Distributor or Provider at the time required, assisting with the prior authorization process, tracking shipments and inventory of my Therapy, and tracking dose and compliance with my prescribed treatment schedule.

By signing this Support Services Authorization, I authorize Sanofi Genzyme and its third party business partners, vendors and other agents ("Agents") to provide me with the Services. I agree that Sanofi Genzyme and its Agents may use and share information about me with my Providers, Caregivers, Payers, PAGs and Distributors for the purpose of providing the Services.

I further authorize Sanofi Genzyme and its Agents to de-identify my health information and use it for Caprelsa Risk Evaluation and Mitigation Strategy (REMS) reporting purposes.

I understand that I do not have to register for the Program and that, if I choose not to register, I can still receive Therapy as prescribed by my physician. I may cancel the Support Services Authorization at any time by writing to the Caprelsa Access Support Program, 11800 Weston Parkway, Cary, NC 27513.

Communications with Sanofi Genzyme and Third Parties: By signing this Support Services Authorization, I also authorize Sanofi Genzyme and its Agents to contact me (or my legal representative) by mail, telephone or email, to provide me information directly or indirectly related to my Disease, Therapy, the Program or the Services ("Sanofi Genzyme Communications").

I further authorize Sanofi Genzyme and its Agents to provide my contact information to select organizations so that they may provide me with additional information or materials on behalf of Sanofi Genzyme that are directly or indirectly related to my Disease, Therapy, the Program or the Services, including, but not limited to, information on disease education/management, treatment protocols or disease-related surveys ("Third Party Communications").

I understand that I may be contacted by Sanofi for follow up information in case I report an adverse event.

Please see full prescribing information for CAPRELSA, including Boxed WARNING, https://products.sanofi.us/caprelsa/caprelsa.pdf, and Medication Guide

Additional Information: By signing this Support Services Authorization and to the extent I have checked the boxes below, I further authorize Sanofi Genzyme and its Agents to contact me (or my legal representative) by mobile or home telephone number and email, as applicable, to send me offers, promotions, and other marketing communications, and mobile service commercial messages, regarding Sanofi Genzyme products, programs and services (collectively, "Additional Information"). I understand that my consent to this Support Services Authorization is not a condition for the purchase or receipt of any products or services from Sanofi Genzyme.

Verifications and Consents: By signing the Services Authorization below, I verify that I am the subscriber or customary user with respect to the home and mobile telephone numbers that I set forth below in the "Patient Information" section and that I have the authority to provide consent, as selected below, to receive the Sanofi Genzyme Communications, Third Party Communications, and Additional Information at those numbers and address. I also verify that I have the authority to provide consent to receive Sanofi Genzyme Communications and Third Party Communications at the **work telephone number** set forth below in the "Patient Information" section.

❑ By checking this box and signing the Support Services Authorization below, I consent to receive commercial calls at the **mobile phone number** provided below in the "Patient Information" section.

I understand that message and data rates may be assessed by my wireless provider for communications to my mobile phone or wireless device.

❑ By checking this box and signing the Support Services Authorization below, I consent to receive commercial calls at the **home phone number** provided below in the "Patient Information" section.

Opt-Out of Certain Communications: I understand that I may opt-out of receiving communcations by home phone, mobile or wireless device, work phone, or email, as applicable, at any time by providing written notice to Caprelsa Access Support Program, 11800 Weston Parkway, Cary, NC 27513.

By signing below, I certify that I have read and understand the Support Services Authorization above and agree to its terms.

Signature: _____ Date: _____

Complete the following only if the person signing and completing this Support Services Authorization is not the Patient.		
Patient's Legal Representative:		
Relationship to Patient: ❑ Custodial Parent	❑ Legal Guardian	❑ Other, please explain:

PATIENT INFORMATION		
Name:		
Date of Birth:		(MM/DD/YYYY)
Street Address:		
City:	State:	Zip Code:
Email:		
Home Phone:		❑ Preferred Number
Work Phone:		❑ Preferred Number
Mobile Phone		❑ Preferred Number

If you sign the Support Services Authorization above, you authorize Sanofi Genzyme, its Agents and certain third parties to contact you (or your legal representative) at the home, work and mobile phone numbers or email you provide here in order to send you Sanofi Genzyme Communications, Third Party Communications, and, to the extent selected by you above, Additional Information.

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

Name	Relationship to Patient
Phone	
Email	
Name	Relationship to Patient
Phone	
Email	
Name	Relationship to Patient
Phone	
Email	
Name	Relationship to Patient
Phone	
Email	

Income Verification Information

Income Verification: I authorize Sanofi Genzyme, its agents and other third parties under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that, upon request, Sanofi Genzyme, its agents and/or other third parties will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize Sanofi Genzyme, its agents and other third parties to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the Patient Assistance Program eligibility determination process, if applicable. I further understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale. If approved for the Sanofi Genzyme Patient Assistance Program, I will not seek to have the value of any medication provided to me under this program counted toward my true-out-of-pocket (TrOOP) cost for prescription drugs for my Medicare Part D Plan. Continuation in the Sanofi Genzyme Patient Assistance Program is conditioned upon timely verification of income. In addition, I agree to notify Sanofi Genzyme, its agents and/or third parties if my insurance situation changes.

Sanofi Genzyme does **not** charge any fees for this service; application processing, medication, and shipping are all offered at no cost. Any fees charged to you by a third party completing this application on your behalf are not required by nor remitted to Sanofi.

By signing below, I certify that I have read and understand the Income Verification and agree to its terms.

Signature:_____ Date: _____

Print name: _____

Authorization to Release 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, 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, and prescriptions (together, "My Information"). My healthcare providers, specialty pharmacies, and Sanofi(including its agents and affiliates) may use and disclose My Information for the purposes of providing certain support services, including benefit verification and drug fulfillment. 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's Global Privacy Policy at https://www.sanofi.com/en/our-responsibility/sanofi-global-privacy-policy

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 and check the box regarding my health information below, Sanofi Genzyme cannot provide me with the 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 Caprelsa Access Support Program, 11800 Weston Parkway, Cary, NC 27513.

I understand that cancelling this Authorization will end my ability to receive the Services but will not affect any disclosure, acquisition, retention or use of my Information made before my request for cancellation 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.

❑ **I consent for the Parties and Sanofi Genzyme and its Agents to disclose, obtain, retain and use my Information as described above.**

Signature:_____ Date: _____

Print name: _____

Please return your completed Form to the Caprelsa Access Support Program.
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