Support Services Authorization

I am registering for a Sanofi support service (the "Program"), which offers the following services related to my medical condition ("Disease") and my Sanofi 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.

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 and its third party business partners, vendors and other agents ("Agents") to provide me with the Services. I agree that Sanofi 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 and its Agents to de-identify my information and use it performing clinical research, business analytics, marketing studies or for other commercial or educational purposes.

I further authorize Sanofi 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 and Third Parties: By signing this Support Services Authorization, I also authorize Sanofi 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 Communications").

I further authorize Sanofi 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 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").

Additional Information: By signing this Support Services Authorization and to the extent I have checked the boxes below, I further authorize Sanofi 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 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.

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 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 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 Capreslsa 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, 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 Communications, Third Party Communications, and, to the extent selected by you above, Additional Information.

I authorize Sanofi 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	

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 Genzyme's Global Privacy Policy at 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 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 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.

1-800-367-4999 • Monday-Friday 9am-6pm ET • Fax 1-888-275-8593