*Patient First Name *Patient Last Name

*Patient Date of Birth

*Policy Holder First Name *Policy Holder Last Name

*Primary Insurance Carrier (if no insurance, enter "None")

*Policy ID # (if no insurance, enter "None") Ins Phone Number (if no insurance, enter "None")

Secondary Insurance Carrier (i.e. Medicare, Medicaid, Tricare, Other)

Prescription Drug Plan(PDP) Name

PDP Phone # PDP ID#

*Physician First Name *Physician Last Name

*Street Address #1 (if unknown, enter "Unknown")

Street Address #2 *City

*State *Zip Code *Physician Phone #

Please review the following authorizations for enrollment in the CareConnect PSS® Co-Pay Program (Co-Pay Program) and the use of your personal health information and, if you wish to proceed under the terms stated, sign below. By typing or drawing your name below, you represent that you intend to be bound by the foregoing terms and that you intend for your typed name to constitute the equivalent of your handwritten signature for purposes of the Program Authorization and Authorization to Share Health Information.

PROGRAM AUTHORIZATION By signing below, I am enrolling in the Co-Pay 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 Co-Pay Program, I acknowledge and understand that (1) the Co-Pay Program will pay 100% of my eligible out-of-pocket drug costs for my covered drug up to the Co-Pay Program maximum, and (2) I will be responsible for paying any amounts over the Co-Pay Program maximum. By signing this Co-Pay Program Authorization, I authorize Sanofi 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 Co-Pay Program; (ii) contact me by mail, telephone and/or email in connection with the Co-Pay Program; and (iii) de-identify my information and use it in performing business analytics and marketing studies or for other commercial purposes. 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 Co-Pay 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 Co-Pay 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. In accordance with state law, infusion-related costs are not covered for commercially insured individuals residing in MA, MI, or RI. Charitable Access Program patients residing in these states are eligible for the Co-Pay Program. The Co-Pay Program runs from January 1 through December 31 of the current calendar year. I understand that I may need to re-enroll each year in order to confirm continued eligibility.

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 Genzyme Corporation (together with its affiliates, including Sanofi, "Sanofi Genzyme") and its third-party business partners and other agents ("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 CareConnect PSS Co-Pay Program (Co-Pay 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 Co-Pay Program. This Authorization shall remain in effect through my participation in the Co-Pay 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 send an email to copay.program@sanofi.com, and include my name and address. I understand that canceling this Authorization will end my participation in the Co-Pay Program and will not affect any use or disclosure of the Information made before my request is received and processed.

I attest and understand the following:

The CareConnectPSS Co-Pay Program (Co-Pay Program) does not cover prescriptions eligible to be reimbursed, in whole or in part, by Medicaid, Medicare (including Medicare Part D), Medigap, Medicare Advantage Plans (Example: Freedom Blue offered through Blue Cross Blue Shield), Veterans Affairs, Department of Defense, Tricare or other federal or state programs (including any state prescription drug assistance programs). No claim for reimbursement of any out-of-pocket expense amount covered by the Co-Pay Program may be submitted to any third-party payer, whether public or private. The Co-Pay Program is available only in the United States and cannot be combined with any other rebate/coupon, free trial, or similar offer. Sanofi Genzyme reserves the right to rescind, revoke, or amend this program without notice.

By electronically signing below, I certify that I have read, understand and agree to the terms of the Co-Pay Program Authorization and Authorization to Share Health Information, and I represent that I:

- The applicant is at least 18 years old; or
- The patient's legal representative

Print Name: Date of Birth:

*Your Signature: *Your Email Address: