SANOFI

PATIENT Connection

SYNVISC APPLICATION

1. PATIENT INFORMATION

First Name: MI: Last Name: Gender: ☐M ☐F

Address: City: State: Zip Code:

Phone #: Date of Birth: Social Security #:

Email Address: Primary Language: Insurance? ☐Yes ☐No

Primary Insurance:		Secondary Insurance:	
Insurance Phone #:		Insurance Phone #:	
Medical Policy #:	Group #:	Medical Policy #:	Group #:
Policy Holder Name:	DOB:	Policy Holder Name:	DOB:
Pharmacy:		Pharmacy:	
Pharmacy Phone #:		Pharmacy Phone #:	
Pharmacy Policy #:	Rx BIN #:	Pharmacy Policy #:	Rx BIN #:

2. DIAGNOSIS AND PRESCRIBING INFORMATION

☐ M17.0 ☐ M17.10 ☐ M17.11 ☐ M17.12 ☐ M17.2 ☐ M17.30 ☐ M17.31 ☐ M17.32
☐ M17.4 ☐ M17.5 ☐ M17.9 ☐ Other:

Please see page 3 for code explanations.

☐ SYNVISC ONE HYLAN G-F 20 8mg/mL (1) 10mL prefilled syringe

Inject 1 Synvisc-One syringe into the:
☐Left knee ☐Right knee ☐Bilateral
Date needed: Qty kits:

☐ SYNVISC HYLAN G-F 20 8mg/mL (3) 2.25mL prefilled syringes

Inject 1 Synvisc Syringe weekly for 3 weeks into the:
☐Left knee ☐Right knee ☐Bilateral
Date needed: Qty kits:

Has the patient had any sodium hyaluronate drug treatments in the past? ☐ Yes ☐ No

If yes, has it been less than 6 months since the last sodium hyaluronate injection for the SAME knee? ☐ Yes ☐ No

If yes, last injection date: Site of last injection: ☐Left knee ☐Right knee ☐Bilateral

3. BUY AND BILL OR SPP TRIAGE SERVICE

1. If both options are available, indicate your preference: ☐Buy and Bill ☐*Specialty Pharmacy
2. If SPP is the only option, do you want your Rx to be triaged to the Specialty Pharmacy? ☐*Yes ☐No

SPC will conduct a complete benefit verification for your patient. If SPP is selected, kindly advise your patient to settle their copay with the pharmacy as soon as possible to avoid delays in treatment; as product will only be shipped after their copay has been received.

**The Program will triage the prescription to the most cost-effective specialty pharmacy in order to dispense Synvisc to the above named patient. If there are multiple options at the same cost to the patient, Synvisc Connection will select which specialty pharmacy to contact via a rotational basis across the program. State law may require the pharmacy to contact the prescriber directly.*

4. PRESCRIBER INFORMATION

Prescriber Name: Prescriber Type: State Where Licensed:

State License #: NPI #: Tax ID #: DEA #:

Treating Physician Name (if different from prescriber): State Where Licensed:

State License #: NPI #: Tax ID #: DEA #:

Facility Name: Facility Type: ☐Physician Office ☐Hospital Outpatient

Facility Address*: City: State: Zip Code:

Additional shipping instructions or address, if different from facility address above*:

Primary Contact Name: Title/Role: Primary Phone #:

Primary Fax #: Email Address:

**Sanofi product must be shipped to the signing prescriber's office or hospital address authorized by the prescriber and not to a 3rd party.*

I certify that the information provided is current, complete, and accurate to the best of my knowledge. I certify that the Sanofi product is medically necessary for this patient and that I am authorized under State law to prescribe and dispense the requested medication. I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification, medical and insurance information to Sanofi US and/or Sanofi Cares North America and their agents and representatives. I understand that any information provided is for the sole use of the Program to verify my patient's insurance coverage, to assess, if applicable, patient's eligibility for participation in the Patient Assistance Program and to otherwise administer the Sanofi Patient Connection program and related services. I understand that I am under no obligation to prescribe any Sanofi product and that I have not received nor will I receive, any benefit from Sanofi or their agents or representatives for prescribing a Sanofi product. The facility address noted above in Section 4 is my office or hospital address. My signature certifies that any prescription products received from this Program will be used for the above-named patient only and will not be resold nor offered for sale, trade or barter and will not be returned for credit, nor will payment be sought from any payer, patient or other source for product received from the Program.

SIGN HERE

Prescriber Signature (required – no stamps) Printed Name Date

P: 1.800.982.8292 · F: 1.888.847.1797 · www.visitspconline.com
P.O. Box 222138 · Charlotte, NC · 28222-2138

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5. RESOURCE CONNECTION

Does the patient want the Program to help identify resources provided by other organizations?

☐ Yes (PATIENT SIGNATURE FOR AUTHORIZATION REQUIRED)
☐ No

Please note: The patient will receive a separate call from a program associate with contact information for helpful resources checked on the application.

If yes, please mark which resources the patient may be interested in if available:

☐ Clinical Support Services
☐ Transportation Information
☐ Health Supplies

6. PATIENT ASSISTANCE CONNECTION *(certification and authorization to disclose information)*

Household size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other: Annual Household Income: $

Please read the following carefully, then date and sign where indicated below.

Income Verification: Sanofi Patient Connection and its authorized third party agents will use my date of birth or social security number and/or additional demographic information as needed to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact my credit score. Sanofi Patient Connection and its authorized third party agents reserve the right to ask for additional documents and information at any time.

I state that the information and documents provided in connection with this application are complete and accurate. I agree to immediately inform a Program representative and my Doctor/ Healthcare Provider if my income or insurance status changes during the course of my participation in this Program.

HIPAA Consent: I authorize my healthcare providers and staff; my health insurer, health plan or programs that provide me health benefits (together, "Health Insurers") to disclose to, Sanofi US, its affiliated companies (i.e. Sanofi Pasteur U.S. and Genzyme, a Sanofi Company), Sanofi Cares North America, and authorized third party agents involved in administration of this Program, (collectively "Program Sponsor"), health information about me, including information related to my medical condition, treatment, health insurance coverage, claims, prescriptions and referral to and enrollment in this Program for purposes of determining my participation in, and administering, the Program, which may include contacting me as well as my Doctor/Healthcare Provider, office/hospital staff, insurer (public/private) or others. I understand a representative from Sanofi may contact me for follow-up on any adverse event I may report regarding a Sanofi product. I authorize and consent to release of identifiable information about me including medical, financial and insurance records and information as required for participation in the Program. I understand that identifiable information about me will be kept confidential and will not be further used or disclosed except to administer the Program, or as required by law. I understand that information I authorize to be disclosed may be re-disclosed and is no longer protected by Federal privacy regulations. I agree that this authorization is voluntary and that I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment but I will not be able to participate in this Program. Unless revoked, this authorization shall remain in effect throughout my participation in the Program, including subsequent reapplication as required. I may withdraw this authorization at any time by written notification to my Doctor/Healthcare Provider; however, withdrawal of authorization will terminate my participation in this Program and will not affect information already disclosed under this Authorization.

I understand that it is my responsibility to follow-up with my prescriber or the Program to make sure that my re-orders, as appropriate, are requested in a timely manner by my Provider so I do not run out of medication. I understand that Sanofi US and Sanofi Cares North America reserve the right at any time and without notice to modify or change eligibility criteria or discontinue this Program.

Patient Authorization (REQUIRED)	I have read and agree to the Patient Authorization to Use and Disclose Health Information above.
Patient/Representative Signature (REQUIRED)	
Printed Name (REQUIRED)	**Date**

APPLICATION CHECKLIST *(application will be delayed if all information is not received)*

☐ Insurance Details
☐ Diagnosis Code checked
☐ Prescriber signature (REQUIRED)
☐ Patient signature (REQUIRED)

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PRODUCT SELECTION *(please enter desired product in section 2 for all services)*

SYNVISC ONE HYLAN G-F 20

Please click here for full
Prescribing Information for Synvisc One.

SYNVISC HYLAN G-F 20

Please click here for full
Prescribing Information for Synvisc.

PATIENT ASSISTANCE CONNECTION ELIGIBILITY REQUIREMENTS

- An application must be submitted for each patient.
- Patient must be a resident of the U.S. or the U.S. territories and be under the care of a licensed healthcare provider authorized to prescribe, dispense, and administer medicine in the U.S.
- Patient must have no insurance coverage or access to the prescribed product or treatment via their insurance.
- Patient must meet the following criteria:
  - Annual household income of ≤400% of the current Federal Poverty Level*
  - If patient may be eligible for Medicaid, they will be required to provide documentation of Medicaid denial before being assessed for patient assistance eligibility
- *To assess current Federal Poverty Level details, visit: http://aspe.hhs.gov.*

ADDITIONAL INFORMATION

- A representative from Sanofi may contact you for follow-up on any adverse event you may report regarding a Sanofi product.

ICD-10 CODE EXPLANATIONS

M17.0 (Bilateral primary osteoarthritis of knee)	**M17.31** (Unilateral post-traumatic osteoarthritis, right knee)
M17.10 (Unilateral primary osteoarthritis, unspecified knee)	**M17.32** (Unilateral post-traumatic osteoarthritis, left knee)
M17.11 (Unilateral primary osteoarthritis, right knee)	**M17.4** (Other bilateral secondary osteoarthritis of knee)
M17.12 (Unilateral primary osteoarthritis, left knee)	**M17.5** (Other unilateral secondary osteoarthritis of knee)
M17.2 (Bilateral post-traumatic osteoarthritis of knee)	**M17.9** (Osteoarthritis of knee, unspecified)
M17.30 (Unilateral post-traumatic osteoarthritis, unspecified knee)	

FORM SUBMISSION OPTIONS

U.S. Mail Sanofi Patient Connection PO Box 222138 Charlotte, NC 28222-2138	**Fax** 1.888.847.1797	**Secure Provider Portal** www.visitspconline.com

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