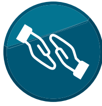
Enjaymo
sutimlimab-jome
Injection for intravenous use
1100 mg/22 mL

ENJAYMO™ Patient Solutions Enrollment Form

Print and fax completed forms to 855-398-7634. Phone: 833-223-2428 www.ENJAYMO.com
Call Us 8 AM - 8 PM EST Monday - Friday

Sanofi reserves the right to modify or terminate these programs at any time without notice.



PATIENT SUPPORT SERVICES
Patient Support Services may be able to provide you with support services, education services, reimbursement services, and related materials. To request Patient Support Services, complete Sections 1-5, 7, and 8.

PRESCRIBER, COMPLETE SECTIONS 3-6

FINANCIAL ASSISTANCE PROGRAMS*
ENJAYMO Financial Assistance Programs may be able to help with the cost of treatment. Access to ENJAYMO at no cost may be available to eligible patients who are uninsured or underinsured. Co-pay assistance may be available for out-of-pocket co-pay or co-insurance costs related to ENJAYMO prescription or infusion costs for eligible patients. To request Financial Assistance Programs, complete Sections 1-5, 7, and 8.

*The ENJAYMO Patient Solutions Co-Pay program (the "Program") is not valid for prescriptions covered by or submitted for reimbursement under Medicare, Medicaid, VA, DoD, TRICARE, or similar federal or state programs including any state pharmaceutical assistance programs. The Program is not valid where prohibited by law and savings may vary depending on patients' out-of-pocket costs. Sanofi reserves the right to modify or terminate the Program at any time without notice. Patients will receive all Program details upon registration. TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

1 PATIENT INFORMATION

To prevent delays, all 3 pages must be received to process enrollment.

PATIENT FIRST NAME ______ LAST NAME ______ MIDDLE INITIAL ______
DATE OF BIRTH ______ LAST 4 DIGITS OF SSN ______ ☐ MALE ☐ FEMALE ☐ OTHER
STREET ADDRESS ______ APT # ______
CITY ______ STATE ______ ZIP ______
CELL PHONE ______ OTHER PHONE ______ EMAIL ADDRESS ______
PREFERRED METHOD ☐ PHONE ☐ EMAIL PREFERRED TIME ☐ MORNING ☐ AFTERNOON ☐ EVENING
CAREGIVER/GUARDIAN (IF APPLICABLE) ______
PATIENT'S PRIMARY LANGUAGE: ☐ ENGLISH ☐ OTHER IF OTHER, PLEASE SPECIFY ______

2 INSURANCE INFORMATION

PLEASE ATTACH COPIES (FRONT AND BACK) OF ALL AVAILABLE INSURANCE AND PRESCRIPTION CARDS. ☐ **NO INSURANCE**
PRIMARY MEDICAL INSURANCE NAME ______
INSURANCE PHONE # ______ POLICY ID # ______
GROUP # ______ POLICYHOLDER NAME (FIRST/LAST) ______
EMPLOYER OF POLICYHOLDER ______ RELATIONSHIP TO PATIENT ______
CURRENT ADDRESS ______ CITY ______ STATE ______ ZIP ______
PRESCRIPTION DRUG INSURANCE NAME (IF DIFFERENT) ______
INSURANCE PHONE ______
POLICY ID # ______ GROUP # ______
Rx BIN # ______ Rx PCN # ______

SECONDARY MEDICAL INSURANCE NAME ______
INSURANCE PHONE # ______ POLICY ID # ______
GROUP # ______ POLICYHOLDER NAME (FIRST/LAST) ______

REQUIRED FOR THE ENJAYMO PATIENT ASSISTANCE PROGRAM
CURRENT ANNUAL GROSS INCOME ______ NUMBER OF HOUSEHOLD MEMBERS (INCLUDING PATIENT) ______
(PLEASE INCLUDE: BEFORE-TAX WAGES, PENSION, INTEREST/DIVIDENDS, SOCIAL SECURITY BENEFITS, AND ANY OTHER SOURCES OF INCOME)

Patient to Fill Out

3 PRESCRIBER INFORMATION

PRESCRIBER'S FIRST NAME ______ LAST NAME ______
PRESCRIBER'S TITLE ______
OFFICE CONTACT AND TITLE ______
OFFICE/CLINIC/INSTITUTION NAME ______
CLINIC/HOSPITAL AFFILIATION ______
STREET ADDRESS ______ SUITE # ______
CITY ______ STATE ______ ZIP ______
PHONE ______ FAX ______
NPI # ______ LICENSE # ______
SPECIALTY OF PRESCRIBER ______

4 INFUSION SITE LOCATION

☐ **I HAVE NOT IDENTIFIED AN INFUSION SITE**
PLEASE SPECIFY INFUSION SITE LOCATION IF KNOWN: ☐ OFFICE ☐ INFUSION CENTER ☐ PATIENT'S HOME (SEPARATE NURSING ORDERS WILL BE REQUESTED)
IF INFUSION CENTER NAME IS KNOWN AND DIFFERENT FROM PRESCRIBER ABOVE, PLEASE PROVIDE: NAME ______
STREET ADDRESS ______ SUITE # ______
CITY ______ STATE ______ ZIP ______
PHONE ______

Prescriber to Fill Out

Enjaymo
sutimlimab-jome
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5 CLINICAL INFORMATION

DIAGNOSIS CODE (*ICD-10* CODE): ________________ WEIGHT ________ (☐ kg/☐ lb) DATE RECORDED ________

6 PRESCRIPTION INFORMATION

PATIENT NAME (FIRST, MI, LAST) ________________ DATE OF BIRTH (MM/DD/YYYY) ________

MEDICATION: ENJAYMO (sutimlimab-jome) 1100 mg/22 mL (50 mg/mL)

DIRECTIONS FOR USE & QUANTITY		ADMINISTRATION
☐ 6.5 g **STARTING DOSE**: Administer 6 vials IV weekly for the first 2 weeks Dispense #12 vials	☐ 6.5 g **ONGOING DOSE**: Administer 6 vials IV every 2 weeks Dispense #12 vials	**ENJAYMO is for intravenous infusion only. Do not administer as an intravenous push or bolus. The infusion should be administered over 1 to 2 hours depending on the patient's body weight.**
☐ 7.5 g **STARTING DOSE**: Administer 7 vials IV weekly for the first 2 weeks Dispense #14 vials	☐ 7.5 g **ONGOING DOSE**: Administer 7 vials IV every 2 weeks Dispense #14 vials	
☐ Refill: None	☐ Refill: 12 months ☐ Other ________	

ESTIMATED DATE OF FIRST INFUSION OF ENJAYMO ________________

SPECIAL INSTRUCTIONS FOR INFUSION SITE OR PHARMACY ________________

I acknowledge that I have obtained authorization to release the patient's personal health information and the information on this form and any prescription to Genzyme Corporation (together with its parents and affiliates "Sanofi") and its third-party business partners, vendors, and other agents ("Agents"), for the purpose of providing product support services (the "Programs"). I further certify that any service provided by Sanofi and its Agents on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use any Sanofi product or service for anyone, and my decision to prescribe ENJAYMO was based solely on my determination of medical necessity. I understand that my information may be used by Sanofi and its Agents to manage and improve the Programs, to communicate with me about my experience with the Programs, and/or to send patient materials relating to the Programs. With respect to any free product provided to the patient listed above, I understand that provision of the product is not contingent on any purchase obligations. I also understand that no claim for reimbursement will be submitted to Medicare, Medicaid, or any third-party payer for medication received free of charge under the Program, or for related medical procedures and services; nor should the free product be sold, traded, or distributed for sale. I will notify the patient's dispensing pharmacy immediately if ENJAYMO is no longer medically necessary for this patient's treatment or if my patient's insurance status changes. I authorize Sanofi as my designated agent and on behalf of my patient to (1) forward the above service request form and furnish any information on this form to the insurer of the above-named patient and (2) forward the above prescription, by fax or other mode of delivery, to the dispensing pharmacy for fulfillment.

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/ No Substitution/DAW/May Not Substitute
Prescriber's Signature: ________________ Date: ________

May Substitute/Product Selection Permitted/Substitution Permissible
Prescriber's Signature: ________________ Date: ________

CA, MA, NC & PR: INTERCHANGE IS MANDATED UNLESS PRESCRIBER WRITES THE WORDS "**NO SUBSTITUTION**." ________________

ATTN: NEW YORK AND IOWA PROVIDERS, PLEASE SUBMIT ELECTRONIC PRESCRIPTION.

Prescriber to Fill Out

7 AUTHORIZATION TO RELEASE HEALTH INFORMATION

By signing this Authorization to Release Health Information ("Authorization"), I authorize my healthcare providers (including my pharmacies), and my health plans and insurers (and their contractors) (collectively, the "Parties") to disclose to Genzyme Corporation (together with its parents and affiliates "Sanofi") and its third-party business partners, vendors, and other agents ("Agents") information about my disease, treatment, insurance coverage and payment for my therapy ("my Information") for the purposes of Sanofi and its Agents providing me with patient support services and sending me communications that I have agreed to receive elsewhere in this Enrollment Form. The Parties and Sanofi and its Agents may use and disclose my Information for the purposes of providing certain support services I agree to in this Enrollment Form, including, but not limited to: (1) determining if I am eligible to participate in the ENJAYMO Patient Solutions Program ("the Program"); (2) to manage and improve the Program; (3) to communicate with me about my experience with the Program; (4) to send materials relating to the Program; (5) investigating my health insurance coverage; (6) operating and administering the Program; and (7) contacting me for follow-up on any adverse event I may disclose regarding a Sanofi product. I further authorize Sanofi and its Agents to de-identify my health information and use it in performing research, education, business analytics, and marketing studies, or for other commercial purposes, including linkage with other de-identified information Sanofi may receive from other sources.

I understand that once my Information has been disclosed to Sanofi and its Agents, federal privacy laws may no longer protect the Information from further disclosure, but that Sanofi and its Agents intends to use and disclose my Information only in accordance with this Authorization or as otherwise allowed by law. I understand that Sanofi and its Agents may provide my pharmacy with payment in order to obtain my Information.

I understand that I may refuse to sign this Authorization 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, Sanofi and its Agents cannot provide me with support services. Authorization expires 5 years from the date I signed unless subject to applicable law unless or until I withdraw (take back) this Authorization before then. I understand that I may withdraw this Authorization at any time by sending a written notice that includes my name, address and phone number to Sanofi ATTN: RBD Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by emailing RBDPatientSolutions@sanofi.com.

Withdrawal of this Authorization will end further reliance on this Authorization (and my participation in the Program) but it will not affect any use or disclosure of my Information before my notice of withdrawal 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.

________________ PATIENT SIGNATURE ________________ PRINT NAME ________ DATE

________________ PARENT/GUARDIAN SIGNATURE (REQUIRED FOR PATIENTS UNDER 18 YEARS OLD) ________________ PRINT NAME ________ DATE

(OPTIONAL) IN ADDITION, I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION TO THE FOLLOWING DESIGNATED INDIVIDUAL:

________________ PRINT NAME ________________ RELATIONSHIP

Patient to Fill Out

8 PATIENT SUPPORT SERVICES AND FINANCIAL ASSISTANCE AUTHORIZATION

☐ **Check this box to agree to Patient Support Services**

I authorize Sanofi and its Agents to provide me with various therapy support services for which I am eligible, which may include but are not limited to: online support, patient education compliance and persistency support, insurance benefits verification and reimbursement support (if requested), coverage and financial assistance support, and such other support services as may be added in the future, as well as any information or materials related to such support services. I acknowledge and understand that Sanofi and its Agents cannot provide me with medical advice, and I will direct all treatment-related questions to my healthcare professional.

I understand and agree that Sanofi may contact me about such services and information by mail, email, telephone call, fax, or text message to the mobile phone number I provided on the enrollment form (including autodialed; message and data rates may apply), or other means at the telephone numbers, email, and mailing addresses I provide. I understand a representative from Sanofi 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 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 sending a written notice that includes my name, address and phone number, to Sanofi ATTN: RBD Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by emailing RBDPatientSolutions@sanofi.com. Sanofi reserves the right to modify or terminate any or all support services at any time without notice.

☐ **Check this box to request participation in the Financial Assistance Programs**

I confirm that my personal and insurance information provided on my enrollment form is accurate.

If enrolling in the ENJAYMO™ sutimlimab-jome Injection for intravenous use 1100 mg/22 mL Co-Pay/Coinsurance Assistance Program (the "Co-Pay Program"), I acknowledge and understand that (1) I am responsible for paying any out-of-pocket amounts over the program maximum; (2) in-patient medication is not covered by the program; (3) the Co-Pay Program does not cover costs associated with administration of therapy such as office visits, procedures, or physician-related services, or other professional services; (4) the Co-Pay Program will pay 100% of my eligible co-pay, coinsurance, and other out-of-pocket expenses up to the program maximum; and (5) patients who start utilizing state or federal government-funded health coverage during their enrollment period will no longer be eligible. I confirm that my personal and insurance information in this form are accurately completed. I certify that I am not a beneficiary of a federal or state healthcare program and that ENJAYMO is not covered by and will not be submitted for reimbursement under any state or federal program, including but not limited to Medicaid, Medicare, VA, DoD, TRICARE, or any state pharmaceutical assistance programs. I will notify Sanofi RBD Patient Services immediately if my insurance status changes. By signing this Co-Pay Program Authorization, I authorize Sanofi to use and share information about me with my healthcare providers, specialty pharmacy providers, and my insurance company for the purpose of coordinating my enrollment and participation in the Co-Pay Program.

*Not valid for ENJAYMO prescriptions covered by or submitted for reimbursement under Medicare, Medicaid, VA, DoD, TRICARE, or similar federal or state programs including any state pharmaceutical assistance programs. Not valid where prohibited by law. Savings may vary depending on patient's out-of-pocket costs. Upon registration, patient will receive all program details.

If enrolling in the ENJAYMO Patient Assistance Program ("PAP"), which provides drug at no cost to patients who are uninsured or underinsured and meet all eligibility requirements of the PAP, I understand that this is not a replacement program. I certify that all of the information submitted on my enrollment form, including information about my household income and the number of people in my household, is complete and accurate. Sanofi RBD Patient Services may use my date of birth and/or additional demographic information as needed to access my credit information and may use information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. Continuation in the program is conditional upon timely verification of income. If requested, I agree to provide Sanofi and its Agents with proof of income within thirty (30) days of the request. I acknowledge that no free product received via the PAP may be submitted for reimbursement to any payer, including Medicare and Medicaid; nor may be sold, traded, or distributed for sale, and I certify that I will not submit any claims for any free product received via the PAP. I also certify that I will not count the free product received via the PAP program towards my true out-of-pocket costs for any insurance plan I may have. I understand that this program is not meant to induce a physician to use or prescribe ENJAYMO.

I will notify Sanofi RBD Patient Services immediately if my income or insurance status changes. Sanofi reserves the right to review assistance requests based on patient need and to change program guidelines or terminate the program at any time without notification.

I also authorize Sanofi and its Agents to contact me by mail, telephone, text message to the mobile phone number I provided on the enrollment form (including autodialed; message and data rates may apply), or email in connection with Financial Assistance Programs and to inform me of available assistance programs, treatment and therapies, and insurance-related information. I understand a representative from Sanofi 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 Sanofi RBD Patient Services Financial Assistance Programs 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 Sanofi ATTN: RBD Patient Services, 50 Binney Street, 3rd Floor, Cambridge, MA 02142, or by sending an email to: RBDpatientsolutions@sanofi.com. Sanofi reserves the right to modify or terminate any or all support services at any time without notice.

☐ **Check this box to agree to receive Sanofi Communications**

I would like to receive additional information about Sanofi products, programs, research studies, services and other topics that may be of interest to me, which may include promotional or educational communications, research opportunities and disease-related surveys (collectively, the "Communications).

I authorize Sanofi, and companies working on Sanofi's behalf, to contact me by mail, email, fax, telephone and/or text message, including via auto-dialer or prerecorded message, using the contact information on this enrollment form to provide me with the Communications (standard message and data rates apply). I understand that I may be contacted by a Sanofi representative or its Agents to provide with the Communications. I also understand that Sanofi may collect and use certain information that I provide (or authorize others to provide) to Sanofi for the purpose of providing me with Communications.

I understand that I do not have to receive the Communications and that agreeing to receive the Communications is not a required condition of receiving any good or services from Sanofi. I may opt out of the Communications at any time by writing to Sanofi, RBD Patient Solutions at 50 Binney Street, 3rd Floor, Cambridge, MA 02142 or calling 855-749-4363.

PATIENT SIGNATURE ______________ PRINT NAME ______________ DATE ______________

Release of Personal Health Information (Section 7 on page 2 of this application) must also be signed to complete enrollment.

Patient to Fill Out

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