Thyrogen®(thyrotropin alfa) Co-Pay Assistance Program Application

Please complete both pages of this application, sign and fax to 1-888-326-1002
You can also mail it to: ThyrogenONE® Program, 6000 Park Lane, Pittsburgh, PA 15275
You can also apply for co-pay assistance by going to website. Visit: www.thyrogen.com

Contact Information

I am (please check one):

☐ Applying for myself

☐ Applying as the patient's custodial parent or legal guardian (relationship): _____

Patient's First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Email Address: _____

Phone Number: _____

Gender: M_____ F_____ Non-Binary _____

Eligibility Information

1. Are you a resident of the United States or a U.S. territory? ☐YES ☐NO
2. Do you have commercial or private insurance? ☐YES ☐NO
3. Are your prescriptions paid for in part or in full under any state or federally funded programs, including but not limited to Medicare, Medicaid, VA, DoD, Tricare, or similar federal or state programs? ☐YES ☐NO
4. Are your prescriptions paid in part or in full by the military? ☐YES ☐NO
   If you answered yes to questions 3 or 4, you are not eligible for co pay assistance. Please contact ThyrogenONE at 1-888-497-6436 with questions.

Health Insurance Information

Primary Insurance Carrier: _____

Policy ID Number: _____

Telephone Number: _____

Physician Information

Please fill in the following information about the doctor prescribing Thyrogen for you.

Physician First Name: _____ Physician Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Physician Office Contact (Name and Number): _____

For questions regarding the completion of this application form please call ThyrogenONE at 1-88-THYROGEN (1-888-497-6436)

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Authorization to Share Health Information

I authorize my healthcare providers and staff 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 Global Privacy Policy at www.sanofi.com/en/our-responsibility/sanofi-global-privacy-policy. I understand that this Authorization expires 18 months from the date support is last provided under the Program, or until my local state law requires expiration, subject to applicable law, unless and until I withdraw (take back) this Authorization before then, or as otherwise required by law. Further, I understand that I may withdraw this Authorization at any time by mailing or faxing a written request to [fill in contact information of Program]. I understand that if I decline to sign this Authorization, it will not affect my eligibility to obtain medical treatment, my ability to seek financial assistance from other sources, or my insurance enrollment or eligibility for insurance coverage.

By signing below, I certify that I have read and understand the Authorization to Share Health Information and agree to its terms.

Name: _____(Print Name)

Signature:_____ Date: _____

Program Authorization

I am applying for the Thyrogen Co-Pay Assistance Program (the "Program"), provided by Corporation (together with its affiliates, including Sanofi, "Sanofi") and its third party business partners, vendors and other agents ("Agents"). Those with federal and state government insurance, such as Medicare, Medicaid, or TRICARE® are not eligible. Sanofi reserves the right to modify or discontinue the programs at any time.

If I am determined to be eligible for the Program, I acknowledge and understand that (1) the Program will pay 100% of my eligible out-of-pocket drug costs for Thyrogen up to the Program maximum of $1,000, (2) I will be responsible for paying any amounts over the maximum, and (3) the administration or injection related costs are not covered under the Program.

By signing this Program Authorization, I authorize Sanofi and its Agents to use and share with my healthcare providers, specialty pharmacies and insurers information about me for the purpose of coordinating my enrollment and participation in the Program. I also authorize Sanofi and its Agents to contact me by mail, telephone, and/ or email in connection with the Program and to inform me of available assistance programs, treatment and therapies, and insurance-related information. I further authorize Sanofi and its Agents to de-identify my health information and use it in patient and community education, business analytics, marketing studies or for other commercial purposes. I understand that I may be contacted by Sanofi if I report an adverse event.
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 to confirm continued eligibility.

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 writing to the ThyrogenONE, 6000 Park Lane, Pittsburgh, PA 15275 or by faxing a letter to 1-888-326-1002. For more information about your privacy rights, please reference Sanofi's Global Privacy Policy at sanofi.com/our responsibility/sanofi-global-privacy-policy.

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

Name: _____(Print

Name) Signature:_____ Date: _____

IMPORTANT NOTICE: The Co-Pay Program does not cover prescriptions eligible to be reimbursed, in whole or in part, by Medicaid, Medicare (including Medicare Part D), or other federal or state programs (including any state prescription drug assistance programs). No claim for reimbursement of any out-of- pocket 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. Co-Pay benefits are not transferable. Sanofi reserves the right to rescind, revoke, modify, or amend this program without notice. Through your participation in the Co-Pay Program, you understand and agree to comply with the terms and conditions set forth above.

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