

LEMTRADA Service Form

One to One Support Services for LEMTRADA are designed to support you on your treatment journey. These services are optional, but if you don't enroll, you'll miss out on the comprehensive and personalized services offered by One to One.

Support you will receive

If you sign up for these optional services, Sanofi will help you on your treatment journey with LEMTRADA. Once your completed and signed LEMTRADA Service Form is received, you will get the following:

- **Personal support:** You will have access to support from a dedicated One to One Case Manager during regular call center hours and an on-duty case manager 24/7.*
- **Financial support services:** You can get reimbursement support, benefits verification, and financial assistance, including, if you're eligible, co-pay assistance† to cover your out-of-pocket costs for the medication and up to \$100 of infusion administration costs per infusion day.
- **Monitoring reminders:** We will help remind you of your required monthly monitoring appointments by either text,‡ call, email, or mail.
- **Educational resources:** Easily accessible tools are available via the Internet, text, and email to help you better understand your disease.
- **Support for your family and care partners:** Your family, friends, and care partners are important in your treatment journey. Helpful resources are available to them.

*Regular call center hours are Monday–Friday 8:30 am–8:00 pm ET. Remember that One to One Case Managers do not provide medical advice. Contact your healthcare provider with any questions about your individual health.

† Patients who have coverage or prescriptions paid for, in part or in full, under Medicare, Medicaid, or other state or federally funded healthcare programs are not eligible. The LEMTRADA Co-Pay Program is subject to termination or modification at any time. If you are not eligible for the LEMTRADA Co-Pay Program and need help with out-of-pocket expenses, One to One Support Services can help review your coverage options. Depending on your specific situation, your One to One Case Manager can direct you to other patient assistance programs that may offer you financial support. Treatment-related, infusion out-of-pocket costs are not reimbursable in MA, MI, or RI.

‡ We will only text you with your permission; some fees may apply.

LEMTRADA Service Form

Please fax this completed form to One to One at 1-855-557-2478

All fields are mandatory. This document supports the operation of the LEMTRADA REMS.

PATIENT INFORMATION (PLEASE PRINT)			PATIENT SERVICES ENROLLMENT	
Name (Last, First)			By signing below, I agree to the Patient Services Enrollment terms on the next page of this form.	
Date of Birth (MM/DD/YYYY)	Gender: ☐ Male ☐ Female		Signature of Patient or Patient Representative	
Street Address 1				
Street Address 2			Date	
City	State	ZIP Code	Email (if you would like to receive email communications)	
Home Number (only one is mandatory)		Mobile Number (only one is mandatory)		
Preferred Number: ☐ Home ☐ Cell		Okay to leave a message: ☐ Yes ☐ No		
Put a check mark next to the therapies you have used in the past.*				
☐ Aubagio® (teriflunomide)		☐ Mavenclad® (cladribine)		
☐ Bafiertam™ (monomethyl fumarate)		☐ Mayzent® (siponimod)		
☐ Gilenya® (fingolimod)		☐ Ocrevus® (ocrelizumab)		
☐ Glatiramer acetate injection (Copaxone®, Glatopa®)		☐ PlegriDy® (peginterferon beta-1a)		
☐ Interferon beta-1a (Avonex®, Rebif®)		☐ Tecfidera® (dimethyl fumarate)		
☐ Interferon beta-1b (Betaseron®, Extavia®)		☐ Tysabri® (natalizumab)		
☐ Kesimpta® (ofatumumab)		☐ Vumerity® (diroximel fumarate)		
☐ LEMTRADA® (alemtuzumab)		☐ Zeposia® (ozanimod)		
		☐ None		
		☐ Other _____		
Of the therapies above, what therapy have you used most recently? _____				
Start & Stop Dates of your most recent therapy _____				
Start Date (MM/YYYY)		Stop Date (MM/YYYY)		
			Date	
If signed by a Patient Representative Name (Last, First) (please print)			Relationship to Patient	

THIS SECTION SHOULD BE FILLED OUT BY YOUR HEALTHCARE PROVIDER

PRESCRIBER INFORMATION					
Prescriber Name (Last, First)		NPI Number	Name of Institution or Facility		Tax ID
Office Contact		Street Address	City	State	ZIP Code
Email Address		Phone Number	Fax Number		

*Any trademarks not owned by Sanofi are the property of their respective owners.

Please fax this completed form to One to One at 1-855-557-2478.

If you have any questions, please contact One to One at 1-855-676-6326.

Please see full [Prescribing Information/Medication Guide](#), including serious side effects.

LEMTRADA®
alemtuzumab 12mg

Patient Services Enrollment

I am enrolling in the LEMTRADA Support Services provided by One to One (the “Program”) and authorize Sanofi and its third-party business partners, vendors, and other agents (“Agents”) to provide me with services under the Program as described on page 1 and as may be added in the future. Such services include medication and adherence communications and support, reimbursement and financial support services, and disease and medication education and support for me and my family members and caregivers (together, the “Services”).

I agree that Sanofi and its Agents may use and share with my healthcare providers, specialty pharmacies, and insurers information about me (including information sent to or created by Sanofi as part of the LEMTRADA REMS) in connection with the Services, including informing my healthcare providers about the Services. I also authorize Sanofi and its Agents to contact me with information about disease and Sanofi products, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize Sanofi and its Agents to de-identify my health information, and use it in performing research, education, business analytics, marketing studies, or for other commercial purposes. I understand that Sanofi and its Agents may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services and send the communications listed above. I understand that 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 I can still receive LEMTRADA as prescribed by my physician. I may opt out of individual Services offered by the Program or opt out of the Program entirely at any time by notifying a program representative by telephone (1-855-676-6326), or by sending a letter to One to One Support Services, PO Box 220790, Charlotte, NC 28222-0790. I also understand that the Services may be revised, changed, or terminated at any time.

Authorization to share health information as part of One to One Support Services

I am enrolling in the LEMTRADA Support Services through One to One (the “Program”) provided by Sanofi and its Agents. I authorize my healthcare providers and staff, my health insurer, and any pharmacy that dispenses LEMTRADA to me (a “Pharmacy”) to disclose my health information described in this form to Sanofi and its Agents. This health information includes information related to my medical condition and treatment (including treatment-related dates and whether I receive recommended laboratory monitoring tests), health insurance coverage and claims, prescription information, and referral to and enrollment in the Program (my “Information”). The parties named above may disclose my Information to Sanofi and its Agents to allow them to enroll me in and provide Services under the Program, send the communications, and keep my healthcare providers informed about the Services. All capitalized terms not otherwise defined have the same meaning as those in the Patient Services Enrollment.

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, I understand that Sanofi 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 my Pharmacy and my Laboratory will receive payment from Sanofi for putting together and sending data about its dispensing of LEMTRADA to me or its scheduling or performance of laboratory tests (but not my test results). I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical care, insurance coverage, access to health benefits, or Sanofi medicines. However, if I do not sign this Authorization, I will not be able to receive certain Services under the Program. I understand that this Authorization shall remain in effect throughout my participation in the Program unless and until I take it back.

I may change my mind and take back this Authorization at any time by writing to One to One Support Services, PO Box 220790, Charlotte, NC 28222-0790, or by calling 1-855-676-6326. I understand that taking back this Authorization will mean that I am not able to receive certain Services under the Program, and will not affect any use or disclosure of the Information made before my request is received and processed.

You may keep a copy of this form for your records.

Please see full [Prescribing Information/Medication Guide](#), including serious side effects.

sanofi

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LEMTRADA®
alemtuzumab iv 12mg