AUBAGIO® (teriflunomide) 14 mg tablets

One to One Start Form

AUBAGIO

Fax: 1-855-557-2478

AUBAGIO is available in 14mg and 7mg tablets.

Instructions for Prescribers

To prescribe AUBAGIO® (teriflunomide) utilizing One to One Support Services for AUBAGIO, please follow these steps:

1. Have your patient read the description of One to One Support Services for AUBAGIO on Page 2
2. Have your patient read the Authorizations on pages 2 and 3 and sign in sections I(a) and I(b) on Page 4 if he or she wishes to grant authorization
3. Complete the rest of the Start Form and sign the Prescriber Authorization
4. If available, copy both sides of the patient's insurance card and pharmacy benefit card
5. Fax page 4 of the Start Form with copies of the cards mentioned above to 1-855-557-2478

Your patient will be contacted by a *One to One* Nurse within 2–3 business days to verify his or her benefit information. Your patient will also be contacted by a pharmacy in the AUBAGIO specialty pharmacy network to confirm delivery details.

Please be sure to fill out all sections of the Start Form including Section VI for patients in ***One Start***®. Incomplete areas may delay the start of treatment.

Instructions for Patients

1. Read the overview of One to One Support Services for AUBAGIO on Page 2. If you wish to receive any of these services, you must read the One to One Program Authorization on Page 2 and the Authorization to Share Health Information on Page 3, and sign sections I(a) and I(b) of the Start Form on Page 4 if you wish to grant authorization
2. Your doctor will fill out the rest of the form and fax it back to us
3. Please provide your doctor with your insurance card and pharmacy benefit card
4. You will receive a call from a *One to One* Nurse within 2–3 business days to verify your benefit information. Please note this might come from an unfamiliar phone number
5. You will be contacted by one of the specialty pharmacies in the AUBAGIO pharmacy network to confirm delivery of AUBAGIO directly to your home. Please note this might come from an unfamiliar phone number. It is very important that you speak to the specialty pharmacy so that your medication shipment is not delayed

If you have questions or want to learn more about AUBAGIO, call 1-855-676-6326, visit AUBAGIO.com, or speak with your healthcare provider.

Please see full Prescribing Information, including boxed WARNING and Medication Guide.

SANOFI GENZYME

One to One Support Services for AUBAGIO® (teriflunomide):

One to One Support Services provide support concerning AUBAGIO along the way, every day. One to One is optional, and provides personal support that's truly personal. By signing sections I(a) and I(b) of the Start Form (page 4), you'll have support to:

1. Help verify your insurance benefits, and you may receive therapy at no cost for up to one year if you are an eligible patient, while your benefits are being verified
2. Set up your prescription with a specialty pharmacy
3. Access educational resources for patients and care partners
4. Receive tailored information and suggestions
5. Access your own *One to One* Nurse,* who can answer your questions about your disease, discuss your lifestyle concerns, check your benefits status, and more

One to One is available 24/7. For more information or if you have questions, please call 1-855-676-6326. Regular One to One call center hours are Mon–Fri, 8:30 am–8:00 pm EST. After hours, you will receive a callback within 30 minutes from an on-call nurse.

*Contact your healthcare provider with any questions about your individual health.

One to One Services Authorization

Please read the following and if you agree, sign Section I(a) of the Start Form.

I am enrolling in the One to One Support Services for AUBAGIO patient support program (the "Program") and authorize Sanofi Genzyme (together with its affiliates, "Sanofi Genzyme") and its third-party business partners, vendors, and other agents ("Agents") to provide me with services under the Program, as described above and as may be added in the future. Such services include medication and adherence communications and support, medication dispensing coordination, reimbursement and financial assistance services, disease and medication education, and support services for family members and caregivers (the "Services").

I agree that Sanofi Genzyme and its Agents may use and share with my healthcare providers, specialty pharmacies, and insurers information about me in connection with the Services. I also authorize Sanofi Genzyme and its Agents to contact me by mail, telephone, email or text* with disease information or with information about Sanofi Genzyme products, promotions, services or research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize Sanofi Genzyme 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 Genzyme 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 (the "Communications").

I understand that I do not have to enroll in the Program and that I can still receive AUBAGIO, 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.

*Sanofi Genzyme and its Agents will text only with your permission; standard messaging rates may apply.

Please see full Prescribing Information, including boxed WARNING and Medication Guide.

Please fax this form to 1-855-557-2478 or mail to One to One Support Services, PO Box 220790, Charlotte, NC 28222-0790 - **For general inquiries call 1-855-676-6326.**

SANOFI GENZYME

Authorization to Share Health Information as Part of One to One Support Services

Please read this page carefully and if you agree, sign and date where indicated in Section I(b) of the Start Form. You may keep a copy of this form for your records.

I am enrolling in the One to One Support Services for AUBAGIO patient support program (the "Program") provided by Sanofi Genzyme (together with its affiliates, "Sanofi Genzyme") and its third-party business partners, vendors, and other agents ("Agents"). I authorize my healthcare providers and staff, my health insurer, and my pharmacies to disclose to Sanofi Genzyme and its Agents health information about me, including information related to my medical condition and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the Program (my "Information") for the purposes of enrolling me in and providing services under the Program, and for the purposes of allowing Sanofi Genzyme to send the Communications described in the One to One Services Authorization on page 2.

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 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 the pharmacy that is dispensing my Sanofi Genzyme medication may receive payment from Sanofi Genzyme for the expense of putting together and sending data about its dispensing of AUBAGIO to me. 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 Genzyme medicines. However, if I do not sign this Authorization, I understand that I will not be able to participate in 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 end my participation in the Program, and will not affect any use or disclosure of the Information made before my request is received and processed.

AUBAGIO® (teriflunomide) 14 mg tablets

One to One Start Form

AUBAGIO

Fax: 1-855-557-2478

AUBAGIO is available in 14mg and 7mg tablets.

Please fill out ALL Patient Information sections (blue) and Prescriber Information sections (green).

Ia: One to One Services Authorization

By signing below, I certify that I have read and understand the One to One Services Authorization and agree to the terms on page 2.

X _____

Signature of Patient or Patient Representative

Date

Ib: Authorization to Share Health Information

By signing below, I certify that I have read the Authorization to Share Health Information on page 3 and authorize the disclosure of my Information to Sanofi Genzyme and its Agents as described.

X _____

Signature of Patient or Patient Representative

Date

If signed by a Patient Representative:

Printed Name **Relationship to Patient**

II: Patient Information

Please complete ALL fields.

Gender: ☐ Male ☐ Female **Date of Birth** (mm/dd/yyyy)

First Name **Middle Initial** **Last Name**

Address

City **State** **ZIP Code**

Phone # ☐ **OK to leave a message**

Mobile # ☐ **OK to leave a message**

Email (Sign up for more information on starting AUBAGIO)

Best time to reach me: ☐ **morning** ☐ **afternoon** ☐ **evening**

III: Prescriber Information

Prescriber Name **Prescriber State License #**

Prescriber NPI # **Prescriber Tax ID #**

Primary Contact Name **Primary Contact Phone #**

Title/Role **Primary Contact Email**

Facility Name

Facility Address

City **State** **ZIP Code**

Facility Phone # **Facility Fax #**

Best time to call: ☐ **morning** ☐ **afternoon**

IV: Reimbursement Services

Medical Coverage

Please complete the information below or send a copy of the front and back of the insurance card.

Primary Insurance	**Secondary Insurance**
Primary Policy #	**Secondary Policy #**
Primary Group #	**Secondary Group #**
Policy Holder Name	**Policy Holder Name**
Policy Holder Date of Birth	**Policy Holder Date of Birth**
Primary Insurance Phone #	**Secondary Insurance Phone #**

Pharmacy Benefit Card: Please send a copy of the front and back of the pharmacy benefit card.

V: Treatment and Prescribing Information

ICD-9/Diagnosis: 340 / ICD-10/Diagnosis: G35

Previous Treatments:

☐ **None** ☐ **Yes (Check all that apply)**

- ☐ **Avonex®** (mm/yy): _____ to _____
- ☐ **Betaseron®** (mm/yy): _____ to _____
- ☐ **Copaxone® (20 mg)** (mm/yy): _____ to _____
- ☐ **Copaxone® (40 mg)** (mm/yy): _____ to _____
- ☐ **Extavia®** (mm/yy): _____ to _____
- ☐ **Gilenya®** (mm/yy): _____ to _____
- ☐ **Lemtrada®** (mm/yy): _____ to _____
- ☐ **Plegridy®** (mm/yy): _____ to _____
- ☐ **Rebif®** (mm/yy): _____ to _____
- ☐ **Tecfidera®** (mm/yy): _____ to _____
- ☐ **Tysabri®** (mm/yy): _____ to _____
- ☐ **Other:** _____ (mm/yy): _____ to _____

VI: Commercial Rx Information: AUBAGIO® (teriflunomide) Tablets

Please check a box on the left for medication strength and shipment quantity, and a box on the right for refills.

14mg 28ct wallet (NDC: 58468-0210-2)
Patient should take 14mg once daily by mouth
☐ Ship 3 wallets (28ct/wallet)
☐ Ship 1 wallet (28ct/wallet)

☐ **14mg** Refills up to 12 months (13 28ct wallets/year)

7mg 28ct wallet (NDC: 58468-0211-1)
Patient should take 7mg once daily by mouth
☐ Ship 3 wallets (28ct/wallet)
☐ Ship 1 wallet (28ct/wallet)

☐ **7mg** Refills up to 12 months (13 28ct wallets/year)

Special Instructions: My preferred pharmacy is AcariaHealth p:877.928.5120 f:877.928.5121

VII: *One Start*® Prescription for Eligible Patients* During Benefits Verification

(Optional, at no cost to patient)

☐ **Yes,** I authorize one or more ***One Start***® shipments of AUBAGIO® (teriflunomide) Tablets until the patient's therapy is covered by commercial insurance (up to one year). I authorize the Program to forward this prescription to the ***One Start***® designated pharmacy in order to dispense AUBAGIO Tablets directly to the patient named herein.

☐ **14mg** **NDC:** 58468-0210-1 (14mg 3x5ct wallets)
Patient should take 14mg once daily by mouth

☐ **7mg** **NDC:** 58468-0211-2 (7mg 3x5ct wallets)
Patient should take 7mg once daily by mouth

Special Instructions: My preferred pharmacy is AcariaHealth p:877.928.5120 f:877.928.5121

☐ **No,** I do not authorize ***One Start***® shipments of AUBAGIO® (teriflunomide) Tablets

***Patients insured through Medicaid, Medicare, VA, DOD, TriCare and other governmental insurance are NOT eligible for this program.**

Prescriber Authorization

I authorize Sanofi Genzyme (with its affiliates and its agents, "Sanofi Genzyme"), as my designated agent, to forward the prescription to a specialty pharmacy in order to dispense AUBAGIO tablets to my patient. I understand that State Law may require the pharmacy to contact me directly and that the information I provide on this form, if signed by my patient, will be used by Sanofi Genzyme as herein authorized by my patient. If my patient is not enrolling in the One to One Support Services for AUBAGIO program, I certify that I have my patient's HIPAA authorization for the release of the patient's identification and insurance information to Sanofi Genzyme for benefits verification and coordination of dispensing of AUBAGIO. I understand that I am under no obligation to prescribe any Sanofi Genzyme product and that I have not received nor will I receive any benefit from Sanofi Genzyme for prescribing a Sanofi Genzyme product. I will not seek reimbursement from any third-party payer, patient or other person or entity for any product resulting from this Start Form. I attest that I am not on the HHS/OIG list of Excluded Individuals.

X _____

Licensed Prescriber Signature (required - no stamps)

Printed Name **Date**

Please see full Prescribing Information, including boxed WARNING and Medication Guide.

Please fax this form to 1-855-557-2478 or mail to One to One Support Services, PO Box 220790, Charlotte, NC 28222-0790 - **For general inquiries call 1-855-676-6326.**

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