KEVZARAconnect® | **Patient Consent Form**

Please click here to see Full Prescribing Information, including RISK OF SERIOUS SIDE EFFECTS and Medication Guide.

KEVZARA® (sarilumab) injection 200 mg

Section 1. Patient Information (*required fields)

Patient Name (First, MI, Last)* _____

Date of Birth* ____ /____ /_____ Gender* ☐ Male ☐ Female ☐ Other _____ ☐ Prefer not to disclose

Email* _____

Phone* _____

Address _____

City _____ State _____ ZIP* _____

Preferred Patient Language (if not English) _____

Section 2. Prescriber Information

Healthcare Provider _____ Practice Name _____

City _____ State _____

Section 3. Patient Certifications

I am enrolling in KevzaraConnect® (the "Program") and authorize Sanofi US, Regeneron Pharmaceuticals, Inc., and their affiliates and agents (together, the "Alliance") to provide me services under the Program, as described in this program enrollment form and as may be added in the future. Such services include insurance coverage and financial assistance support ("the Services").

I agree that the Alliance and its agents may use and share with my healthcare providers, specialty pharmacies, and insurers, information about me in connection with the Services.

I authorize the Alliance to contact me by mail, telephone, or email, with information about the Program, the applicable disease, products, promotions, services, and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I authorize the Alliance to de-identify my health information and use it in performing research, including linkage with other de-identified information the Alliance receives from other sources. I understand that members of the Alliance may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services. I understand that I may be contacted by the Alliance in the event that I report an adverse event.

I understand that I do not have to enroll in the Program and that I can still receive KEVZARA® (sarilumab) injection, as prescribed by my physician. I may opt out of individual services offered by the Program, or opt out of the Services entirely at any time by notifying a Program representative by email at KevzaraConnectFRM@sanofi.com. I also understand that the Services may be revised, changed, or terminated at any time without notice.

I have read and agree to the Patient Certifications.

Sign _____ _____

Patient Signature/Legal Representative Signature Date (mm/dd/yyyy)

_____ _____

Printed Name (if signed by a legal representative) Relationship to Patient

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Section 4. Patient Authorization to Use and Disclose Health Information (HIPAA consent)

I authorize my healthcare providers and staff, my health insurer, health plan, or programs that provide me healthcare benefits, and any specialty pharmacies that dispense my medication, to disclose health information related to my medical condition, treatment, insurance coverage, and referral to and enrollment in the Program (collectively, my "Information") that is needed to enroll me in and provide me with the Services under the Program. I understand that the pharmacy that is dispensing my KEVZARA medication may receive payment from the Alliance for the expense of putting together and sending data about its dispensing of KEVZARA to me. 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 also understand that the Alliance will protect my Information by using and disclosing it only for the purposes allowed by me in this Authorization, or as otherwise allowed by law. 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 treatment, insurance coverage, access to health benefits, or Alliance medications. However, if I do not sign this Authorization, I understand that I will not be able to obtain the Services under the KevzaraConnect Program. **I understand that this Authorization expires 5 years from the date support is last provided under the Program**, or until my local law requires expiration, subject to applicable law, unless and until I withdraw (take back) this Authorization before then, or as otherwise required by law. I may change my mind and cancel this Authorization at any time by emailing KevzaraConnectFRM@sanofi.com. I understand that canceling this Authorization will end my participation in the Services and will not affect any use or disclosure of the Information made before my request is received and processed. I understand that I may request a copy of this Authorization.

I have read and agree to the Patient Authorization to Use and Disclose Health Information (HIPAA consent).

Sign

Patient Signature/Legal Representative Signature	Date (mm/dd/yyyy)
Printed Name (if signed by a legal representative)	Relationship to Patient

Fax or send this form to your patient's specialty pharmacy.

sanofi | REGENERON®