AUBAGIO® (teriflunomide) 14 mg tablets

One to One Start Form

Fax: 1-855-557-2478

AUBAGIO is available in 14 mg and 7 mg tablets.

Instructions for Prescribers

To enable your patient to access One to One Support Services for AUBAGIO, including the Co-Pay Assistance Program and *One to One* Nurse support, 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 1 and 2 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 insurance 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 discuss services and programs for which they may be eligible.

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 Services Authorization on page 2 and the Authorization to Share Health Information on page 3, and sign sections 1 and 2 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 discuss services for which you may be eligible. Please note this might come from an unfamiliar phone number

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 1 and 2 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. Access educational resources for patients and care partners
3. Receive tailored information and suggestions
4. 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 1 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 and its affiliates (collectively, "Sanofi Genzyme") and its third-party business partners, vendors, and other agents ("Agents") to provide me with services for which I am eligible under the Program, as described above and as may be added in the future.

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, and 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 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 calling 1-855-676-6326, writing to One to One Support Services, PO Box 220790, Charlotte, NC 28222-0790, or by faxing a completed form to 1-855-557-2478.

†Sanofi Genzyme and its Agents will text only with your permission; standard carrier 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 2 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 and its affiliates (collectively, "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 cancel this Authorization. I may change my mind and cancel this Authorization at any time by calling 1-855-676-6326, writing to One to One Support Services, PO Box 220790, Charlotte, NC 28222-0790, or by faxing a completed form to 1-855-557-2478. I understand that canceling 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

Reset Form

Fax: 1-855-557-2478

AUBAGIO is available in 14 mg and 7 mg tablets.

Please fill out:

- ***ALL Patient Information sections 1–3 (blue)***
- ***Prescriber Information sections 4–9 (green)***

1: 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

2: 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**

3: Patient Information

Please complete **ALL** fields.

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

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

Address (No PO Boxes)

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

Phone # ☐ **Preferred Number** ☐ **OK to leave a message**

Mobile # ☐ **Preferred Number** ☐ **OK to leave a message**

Email (Sign up for more information on starting AUBAGIO)

Best time to reach me: ☐ **Morning** ☐ **Afternoon** ☐ **Evening**

Preferred Language: **Request Interpreter:** ☐ **Yes** ☐ **No**

4: 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**

5: Medical Coverage

Please complete the information below. Send front and back of Insurance Card and Pharmacy Benefit 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 #**

6: Prior Treatments

ICD-10/Diagnosis: G35

Prior Treatments (check all that apply):

☐ **None**

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

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

Medication Strength & Shipment Quantity — Choose one option

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

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

Refill Quantity — Choose one option

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

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

Special Instructions: ____

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

(Please check Yes or No. *One Start*® is 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.

☐ **14 mg** **NDC:** 58468-0210-1 (14 mg 3x5 ct wallets)
Patient should take 14 mg once daily by mouth

☐ **7 mg** **NDC:** 58468-0211-2 (7 mg 3x5 ct wallets)
Patient should take 7 mg once daily by mouth

Special Instructions: ____

☐ **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.**

9: Prescriber Authorization

I authorize Sanofi Genzyme, its affiliates, and its agents (collectively, "Sanofi Genzyme") 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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