CAPRELSA ACCESS SUPPORT PROGRAM ENROLLMENT AND AUTHORIZATION FORM

Caprelsa® (vandetanib) Tablets

Please see accompanying full Prescribing Information, including Boxed WARNING, for Caprelsa

I wish to enroll so I can begin receiving support services

Patient or Patient's Legal Representative: _____(Print Name)

Patient's Date of Birth: _____(MM/DD/YYYY)

Street Address: _____ City: _____

State: _____ ZIP Code: _____

Preferred Phone Number: ❑ Home Phone: _____

❑ Work Phone: _____

❑ Cell Phone: _____

E-mail Address: _____

Prescriber Name: _____

Street Address: _____ City: _____

State: _____ ZIP Code: _____ Office Phone: _____

If you, as the person signing this form, would like Sanofi Genzyme to discuss the patient's health information as it relates to Caprelsa Access Support Program with someone other than yourself, please identify that person below and their relationship to the Patient and carefully read and if you agree sign the Authorization to Share Health Information below.

Name: _____ Relationship to Patient: _____

Authorization to Share Health Information

By signing this Authorization to Share Health Information ("Authorization"), I authorize my healthcare providers, my health insurers, and the pharmacy that dispenses my medication to disclose to Sanofi Genzyme and its third party business partners, vendors and other agents ("Agents") my health information, and any information supplied in connection with patient's enrollment to the Caprelsa Access Support Program (the "Program"), including but not limited to information related to my medical condition and treatment, insurance coverage and claims, and prescription (the "Information"), for the purposes of providing services under the Program and as described in the Patient Services Authorization below. 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, 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 medication may receive payment from Sanofi Genzyme for the expense of compiling and transmitting data about its dispensing of Caprelsa® (vandetanib).

I understand that I may refuse to sign this Authorization. I further understand that a refusal to sign this Authorization will not affect my ability to obtain medical care, insurance coverage, or access to health benefits, including my access to therapy. However, if I do not sign this Authorization, I understand that I will not be able to enroll in the Program. I understand that this Authorization shall remain in effect throughout my participation in the Program unless and until I cancel it. I may cancel this Authorization at any time by writing to Caprelsa Access Support Program, Biologics Inc., 11800 Weston Parkway, Cary, NC 27513. 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.

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: _____

PLEASE SIGN BOTH

Patient Services Authorization

I am enrolling in the Caprelsa Access Support Program, provided by Sanofi Genzyme and its third party business partners, vendors and other agents ("Agents"). The program provides the following services and other services as may be added in the future (the "Services"): disease and medication support services, reimbursement and financial assistance services, disease and medication education, medication dispensing coordination.

By signing this Patient Services Authorization, I authorize Sanofi Genzyme and its Agents to provide me with 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 for the purpose of providing the Services. I also authorize Sanofi Genzyme and its Agents to contact me by mail, telephone, and email in connection with the Program, to inform me of clinical research studies, treatment protocols and disease-related surveys that may be of interest to me, and to send me information, offers and promotions regarding Sanofi Genzyme products, programs and services, as well as invitations to complete surveys, questionnaires, and other market research studies about my experience with and thoughts about such products, services and programs. I further authorize Sanofi Genzyme and its Agents to de-identify my health information and use it for Caprelsa Risk Evaluation and Mitigation Strategy (REMS) reporting purposes and in performing clinical research, patient and community education, business analytics, marketing studies or for other commercial, medical and scientific purposes.

I understand that I do not have to enroll in the Program and that if I choose not to enroll I can still receive Caprelsa® (vandetanib) as prescribed by my REMS certified physician. I may opt out of the Program at any time by writing to Caprelsa Access Support Program, Biologics Inc., 11800 Weston Parkway, Cary, NC 27513.

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: _____

Please complete form and fax to 888-275-8593. If you have any questions regarding Caprelsa Access Support Program, call 1-800-367-4999.

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