Welcome to Sanofi U.S. This new account welcome kit provides you with essential information on how to request a new account and understand our standard business policies and procedures. Listed below are the action steps you need to take in-order-to apply for a new account.

Documents needed to open an account:

- Sanofi U.S. New Customer Application
  - This application starts the process of opening a new customer account with us. Our Terms and Conditions document is attached. Please review the Terms and Conditions and contact us if you have any questions. A primary contact phone number and email address are required.
- State License
- DEA Certificate or HIN Number (Name and address on license must match application)
- 340B Drug Pricing Program number (if applicable)
- Tax Exemption status and State Tax Exemption or Resale Certificate

Customer partner set up in our system:

Each customer is set up with a Ship To, Sold To, Bill To and Payer account (see definitions below). Please provide a Name and Address for the respective accounts on Page 2 of the New Customer Application. The Supplemental Address Form on Page 5 should be used for additional Ship To addresses as needed.

- ***Ship To: The address of the facility where we ship the product.***
- ***Sold To: The address of the facility which places an order for the product (typically the same as the Ship To name and address).***
- ***Bill To: The address where we will send invoices for the product shipped.***
- ***Payer: The address of the facility that pays for the invoice (the "Credit Applicant").***

Your next step:

- Please complete the New Customer Application and send it, along with the other documents mentioned above, to us via email: SCCustomerEngagement@sanofi.com.

Thank you for choosing Sanofi U.S. If you have any questions about the steps necessary to apply for a new customer account, please contact your sales representative or simply call 1-800-372-6634 to speak with a customer support representative.

New Customer Application

Please email completed form and licenses to: SCCustomerEngagement@sanofi.com

ALL requested information must relate to the customer and/or facility, and not a Sanofi representative.

Ship To Information

The address of the facility where we ship the product.

Facility Name _____

Physician Name, if applicable_____

Address _____

Suite _____

City _____

State _____

Zip _____

Purchasing Contact _____

Phone _____

Fax _____

Purchasing Email _____

DEA #, HIN# or 340b ID#: _____

DEA Expiration Date _____

State License #, **Copy required** _____

SGLN # (Serialized Global Location Number)_____

_____

Bill To Information

The address where we send invoices for the product.

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

State _____

Zip _____

Billing Contact _____

Phone _____

Fax _____

Accounts Payable Email, Required _____

2nd A/P Email Address, Required _____

Email for Invoice (if different) _____

Taxable Status, required Exempt* ☐ Non-Exempt ☐

If exempt, an exemption certificate must be provided.

Sold To Information

The address of the facilities which places order for product.

Check below if Sold to Name/Address is the same as

Ship To ☐

If different, please complete below:

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

Zip _____

State License #, **Copy required** _____

Payer Information

The address where we send invoices for the product.

Check below if Payer Name/Address is the same as

Ship To ☐ Or Bill To ☐

If different, please complete below:

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

Zip_____

Account Information

Type of Facility		Legal Status
☐ Clinic	☐ Mail Order Pharmacy	☐ Public Corporation
☐ Hospital	☐ Department of Defense	☐ Private Corporation
☐ Physician	☐ Veteran Facility (VA)	☐ Partnership
☐ Long Term Care	☐ Independent Retail	☐ Limited Liability Corporation
☐ Specialty Pharmacy	☐ Chain Retail	☐ Sole Proprietor
☐ 340B Entity; 340B#	☐ Other (Please describe below)	☐ Other (Please describe below)
Is your facility, or are you affiliated with, a Hemophilia Treatment Center covered under the 340B program? If yes, please enter your 340B ID:_____		

NOTE: Bank Information and Credit References are required in order to receive terms. If Bank Information and Credit References are not provided, account will be set up with credit card (prepaid) terms.

Bank Information

Bank Name	Your Account Number	Bank Contact Name	Phone or Email

Credit Reference Information (Please provide 3 vendor references)

Company Name	Your Account Number	Company Contact Name	Phone or Email

General Business Information

Are there any prior bankruptcies of principal owners and/or businesses?	☐ No	☐ Yes	
Are there any pending lawsuits against the business?	☐ No	☐ Yes	
How would you like to receive invoices?	☐ EDI	☐ Email	☐ Paper
What is your preferred method of payment?	☐ EFT	☐ Check	☐ Credit Card
If you are part of a healthcare system, please indicate the name:			

What products are you interested in purchasing?				
Anticipated Monthly Purchase Volume	☐ $25,000	☐ $50,000	☐ $100,000	☐ Over $100,000

Terms and Conditions Agreement

Your signature below indicates you are an owner, officer, or authorized buyer of Applicant and Applicant fully accepts the Terms and Conditions of becoming a direct purchasing customer of Sanofi U.S. products.

Form of Verification of Accuracy of Information & Authorizing Credit Check

The undersigned, on behalf of and authorized by the Applicant, hereby certifies the foregoing information, including references and all other documents submitted herewith, are true and accurate in every respect. The foregoing information is being provided in order to allow Sanofi U.S. to determine if the Applicant will be granted credit and will be relied on by The Company in making its credit decision. The undersigned further agrees to notify The Company immediately upon receipt of information that any of the foregoing is not completely accurate. The undersigned further authorizes The Company to gather and use, from time to time without the undersigned's knowledge, any and all financial and/or credit information relating to the Applicant that can be obtained from any source whatsoever. In connection therewith, the undersigned hereby authorizes any and all Bank and Trade references listed above to release to The Company such information as The Company may request in connection with its investigation of the credit worthiness of the Applicant.

_____ _____

Print Name Title

_____ _____

Authorized Signature Date

NOTE: Form must be signed by the prospective customer, not by a Sanofi representative.

Supplemental Address Form*

This form should be used for additional Ship To locations.
Please email completed form and licenses to: SCCustomerEngagement@sanofi.com

ALL requested information must relate to the customer and/or facility, and not a Sanofi representative.

Existing Account Information:

Sold To/Ship To Account Number: _____

Primary contact name, phone number and email are required.

Ship To Information
The address facility where we ship the product.

Facility Name _____
Physician Name, if applicable _____
Address _____
Suite _____
City _____
State _____
Zip _____
Purchasing Contact _____
Phone _____
Fax _____
Accounts Payable Email _____
Email for invoice (if different) _____
DEA # or HIN # 340b ID: _____
DEA Expiration Date _____
State License #, **Copy required** _____
SGLN # (Serialized Global Location Number) _____

Ship To Information
The address facility where we ship the product.

Facility Name _____
Physician Name, if applicable _____
Address _____
Suite _____
City _____
State _____
Zip _____
Purchasing Contact _____
Phone _____
Fax _____
Accounts Payable Email _____
Email for invoice (if different) _____
DEA # or HIN # 340 ID: _____
DEA Expiration Date _____
State License #, **Copy required** _____
SGLN # (Serialized Global Location Number) _____

Is your facility, or are you affiliated with, a Hemophilia Treatment Center covered under the 340B program? If yes, please enter your 340B ID:_____

Tax Exempt Status, required check one: ☐ Exempt ☐ Non-exempt

STATE TAX EXEMPT CUSTOMERS PLEASE ATTACH A COPY OF TAX EXEMPT OR RESALE CERTIFICATE.

NOTE: If an account has more than one Ship To location, please submit a copy of the respective DEA certificate (if applicable) or HIN # for all additional locations. Each active Ship To location must have a unique DEA # or HIN # that matches the Ship To name and address.