PATIENT ENROLLMENT FORM

Thank you for your participation. To complete your enrollment, please fill in all of the following fields.

Patient information		Patient contact information for voucher *(select all preferred methods)*		
First and last name		☐ Home phone	Best time to call ☐ AM ☐ PM ☐ Weekend	☐ Do not leave a voicemail
Date of birth MM/DD/YYYY	Gender ☐ M ☐ F	☐ Other phone	Best time to call ☐ AM ☐ PM ☐ Weekend	☐ Do not leave a voicemail
Street address		☐ Email		
City		Your email will be used to provide educational materials that will help you learn more about how to manage osteoarthritis. At 8 months post-injection, we will contact you with a follow-up survey that will be provided back to your physician. At this time, we will also provide a reminder to make an appointment with your clinic to see if you could benefit from another injection and **offer you a rebate voucher for your second injection**.		
Province	Postal code			

OnTRACK INSURANCE VERIFICATION SERVICE *(OPTIONAL)*

This service requires us to contact your insurer, your spouse's insurer or your employer and helps find alternate payment options. Complete the information below to participate.

☐ Please contact me in order to receive this service

Group health plan *(patient)*		Group health plan *(spouse)*	
Group insurance or plan number		First and last name	Date of birth MM/DD/YYYY
Card number (usually 20 digits)		Group insurance or plan number	Card number (usually 20 digits)
Insurer name	Employer name	Insurer name	Employer name

INITIAL SURVEY FOR NEW OnTRACK PATIENTS

1. Select which option best describes your situation:

☐ I am considering a SYNVISC® injection in the future ☐ This is my first SYNVISC® injection ☐ This is not my first SYNVISC® injection

2. Please indicate which joint was injected: *Please check all that applies.*

Shoulder	☐ Right	☐ Left	☐ Both	**Hip**	☐ Right	☐ Left	☐ Both
Knee	☐ Right	☐ Left	☐ Both	**Ankle**	☐ Right	☐ Left	☐ Both

3. What would you like to gain from your SYNVISC® injection (i.e., objective or goal)?
Please check all that applies.

☐ Increased mobility ☐ Participate in athletics and sports
☐ Mobility post-injury or surgery ☐ Other

4. In the months before your SYNVISC® injection:

A. How much did you know about managing your OA? *Please select one.*
Very little 1 2 3 4 5 6 7 8 9 10 A lot

B. How often did you help to manage your OA by following:

An EXERCISE PLAN? *Please select one.*
☐ Always or frequently ☐ Occasionally ☐ Never or I did not have an exercise plan

A DIET PLAN? *Please select one.*
☐ Always or frequently ☐ Occasionally ☐ Never or I did not have a diet plan

I have read and understood the information provided in this Form (including the Protection of Personal Information section) and accept to participate in the Program.

X _____

Signature for enrollment consent

– FOR CLINIC USE ONLY –

Clinic information	Patient injection information *(filled out by clinic)*
Physician name	Please indicate which product was injected: ☐ SYNVISC® 1 x 2 mL ☐ SYNVISC® 3 x 2 mL ☐ Synvisc-One®
Clinic name and address (MD stamp OK here)	Date of injection MM/DD/YYYY
	Product lot number (on the box or sticker inside)

Fax completed form to PharmaCommunications Group Inc. at 1-800-603-3863

PATIENT ENROLLMENT FORM

OnTRACK with SYNVISC®/Synvisc-One® Program (hereinafter the "Program")

The Program is sponsored by Sanofi Canada in connection with SYNVISC®/Synvisc-One®; for the early and ongoing management of patients with osteoarthritis pain.

Eligible patients who are enrolled in the Program are offered the opportunity to receive educational materials on osteoarthritis, SYNVISC®/Synvisc-One®; obtain reimbursement assistance and provide their physicians with an update on their treatment progress. The Program offers these benefits at no cost to enrolled patients.

Protection of Personal Information

It's important for you to understand how the information you share as part of Sanofi Canada's "OnTRACK with SYNVISC®/Synvisc-One®" Program will be used. At Sanofi Canada, we are committed to respect your privacy rights. This section describes why and how your Personal Information is collected and processed through the Program. Generally stated, by Personal Information we mean any information about an identifiable person including but not limited to your name, address, telephone number, date of birth ("Personal Information"). Sanofi Canada has retained an administrator (identified below) for the administration of the Program including to manage the collection and processing of Personal Information (the "Administrator"). Except for Sanofi Canada's legal requirements and pharmacovigilance duties detailed herein, Sanofi Canada will not have access to any of your Personal Information. Sanofi Canada will only have access to aggregated and unidentifiable statistical information regarding patients registered on the Program.

By accepting to become a member of the Program, you accept to provide us with your Personal Information (such as your name, address, phone number, email address, your birth year, gender, and certain health information). This information will solely be used in relation to the Program. Your Personal Information is collected, used and disclosed for the purposes identified below:

- to create your Program membership;
- to enable you to respond to the Program survey(s);
- to permit us to remind you to talk with your physician regarding a repeat injection of SYNVISC®/Synvisc-One®;
- with your prior permission, to send you materials related to the Program including materials to help you manage your osteoarthritis;
- to remind your physician to contact you regarding a repeat injection of SYNVISC®/Synvisc-One®;
- to provide you with reimbursement assistance, including to communicate with third-party insurers with your consent;
- to respond to your queries and questions;
- for any additional purposes identified at the time of collection;
- for any additional purpose to which a member consents to; and
- as otherwise permitted or required by applicable law.

(collectively the"Purposes")

Your Personal Information will not be shared or disclosed except with:

- the Administrator to manage the collection and processing of the Program's Personal Information. We have contractually ensured that such third-party service provider provides a high level of Personal Information protection and is responsible for the security of the Personal Information. It is not authorized to collect, use or disclose the Personal Information except as necessary to perform services on our behalf in relation to the Program's Purposes as described herein, or to comply with legal requirements; and
- your physician in relation to the Purposes of the Program.

The results of the survey(s) and statistical data related to the Program will be rendered in an aggregated and anonymous manner and shared with Sanofi Canada, healthcare practitioners and other third parties, as the case may be.

Sanofi Canada reserves the right to transfer any Personal Information related to the Program in connection with the sale or transfer of all or a portion of our business or assets or rights relating thereto. Should such a sale or transfer occur, we will request that the transferee use and disclose Personal Information you have provided through this Program in a manner that is consistent with the Purposes disclosed herein.

The Program is not intended to solicit adverse experience for Sanofi Canada products or products of other companies. As a member of the Program, if you provide information about an adverse experience while using any of Sanofi Canada's products, we may use the information you provided to submit reports to Health Canada and/or other relevant regulators.

We may be required to contact you and/or your healthcare professional for further information. You understand that in order to comply with the law, we may not be permitted to meet your request to amend or remove Personal Information you provided to us or a third party regarding an adverse experience while using any of Sanofi Canada's products.

The processing of adverse experiences may include and/or be managed by Sanofi Canada's affiliates or third-party service providers retained specifically for this sole purpose. The information is collected and maintained in a computerized database that is an internal tool used solely for the purpose of conducting pharmacovigilance practices. The database is only accessible to employees, agents or authorized service providers for whom the information is needed in the performance of their pharmacovigilance duties. Some affiliates of the sponsoring pharmaceutical company and authorized third-party services providers are located in countries where there is no personal data protection law or where the level of protection is less than the requirements of your jurisdiction, and Personal Information may be disclosed to foreign government authorities pursuant to lawful requirements of such other jurisdictions. In order to ensure security and limited access to this database, appropriate safeguards and security requirements have been put in place. Nevertheless, the reasonable contractual measures taken to protect Personal Information while processed are subject to applicable foreign legal requirements, for example lawful requirements to disclose Personal Information to government authorities in those countries.

The Administrator will only retain Personal Information as long as needed to fulfill the Purposes. The file containing your Personal Information will be made available to the authorized employees, contractors or agents of the Administrator who need to access the information in connection with the Purposes. The Personal Information will be held primarily in an electronic database.

You have certain rights to access and rectify your Personal Information contained in the file held about you and in order to exercise this right, or if you have any questions or concerns, you may use the contact information provided below. If the Personal Information collected is incorrect, inaccurate or outdated, the Administrator will correct such information within a reasonable period of time.

The Program hereby agrees to respect and observe the provisions set forth in Quebec Act Respecting the Protection of Personal Information in the Private Sector (the "Act") and any other applicable federal or provincial privacy legislation. To the extent there is additional protection afforded to the member pursuant to the Act or any other applicable privacy legislation, and same is not set forth herein, the Program agrees to take such measures to give full effect to such additional protection.

If you have any questions or concerns about our privacy practices or want to have access to and have your Personal Information corrected, please contact the Administrator: PharmaCommunications Group Inc. at: 1-855-332-9444.

This is a completely voluntary Program and you may cancel your participation at any time and without reason by calling 1-855-332-9444. Once you unsubscribe, you will no longer be eligible to continue in the Program, your Personal Information will no longer be used however, any Personal Information already provided at the time of your cancellation may be used in an aggregated and anonymous fashion for the Purposes of the Program. Should your physician withdraw from the Program, we may no longer be able to provide you with certain benefits of the Program.

I understand that this patient enrollment form is available in French and I hereby state my express wish that this form be drawn up in English. **Je comprends que ce formulaire de consentement est disponible en français et je confirme mon intention expresse que ce formulaire soit rédigé en anglais.**

CDN.HYL.17.09.03E 50125484

Fax completed form to PharmaCommunications Group Inc. at 1-800-603-3863

Tips on completing the OnTRACK enrollment form

Follow these instructions to help you complete the form.

1 To be filled out by **patients**

2 Patients should:

1) Provide their contact details

2) Select their preferred method of contact

Email addresses will be used to provide patients with monthly educational emails.

OnTRACK will also contact patients by phone or email to follow up with their treatment 8 months after their injection. At this point, we will provide patients with a follow-up survey to get a **$50 rebate voucher for their next injection** that can only be redeemed by OnTRACK with a proof of purchase.

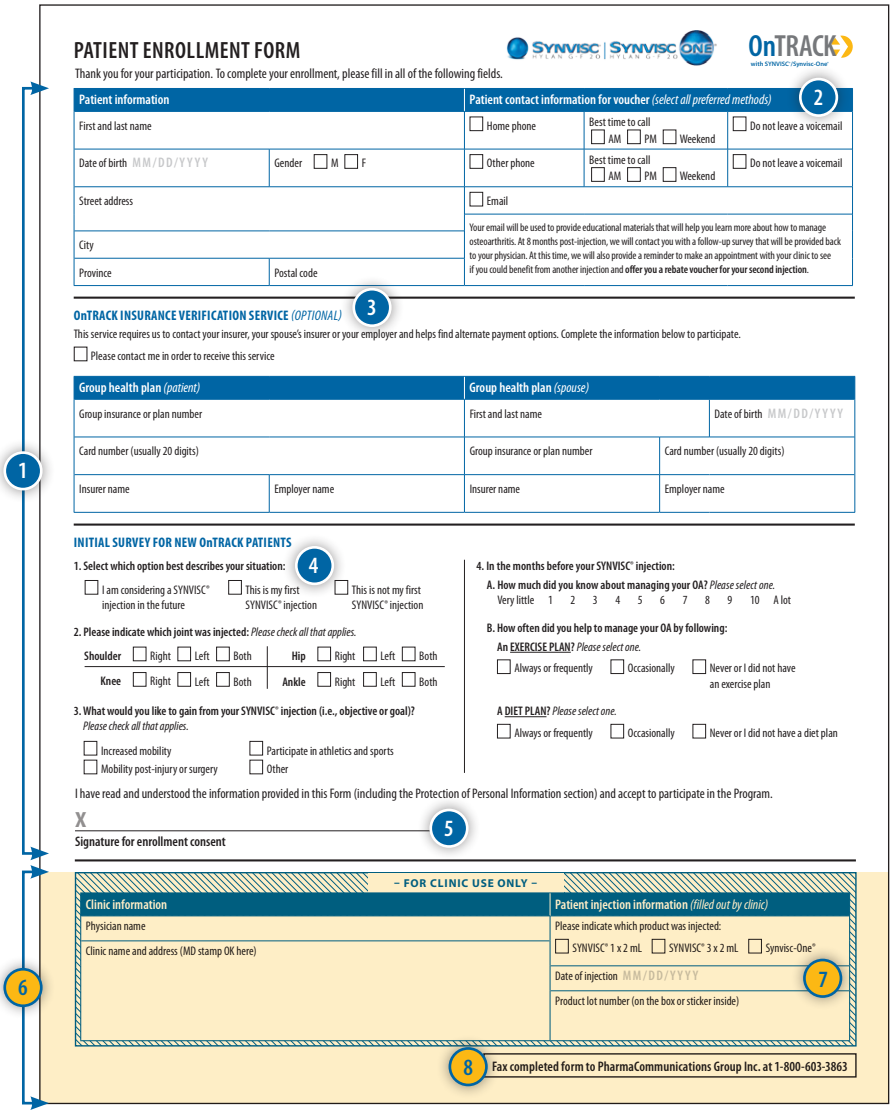
3 The OnTRACK insurance verification service is optional. Patients should check the box and/or provide their information to receive this service.

OnTRACK can:

- Help determine if the patient has insurance benefits and coverage for SYNVISC®, bracing, physiotherapy, a nutritionist, osteopathy and massage therapy
- Work with clinics where patients are covered by Non-Insured Health Benefits (NIHB)
- Help advocate coverage with employers or offer patients the option to pay in three equal payments

4 Complete short survey

5 **Patient signature** is required to provide enrollment consent



PATIENT ENROLLMENT FORM

SYNVISC | SYNVISC ONE HYLAN G-F 20 | HYLAN G-F 20

OnTRACK with SYNVISC/Synvisc-One

Thank you for your participation. To complete your enrollment, please fill in all of the following fields.

Patient information		Patient contact information for voucher *(select all preferred methods)*		
First and last name		☐ Home phone	Best time to call ☐ AM ☐ PM ☐ Weekend	☐ Do not leave a voicemail
Date of birth MM/DD/YYYY	Gender ☐ M ☐ F	☐ Other phone	Best time to call ☐ AM ☐ PM ☐ Weekend	☐ Do not leave a voicemail
Street address		☐ Email		
City		Your email will be used to provide educational materials that will help you learn more about how to manage osteoarthritis. At 8 months post-injection, we will contact you with a follow-up survey that will be provided back to your physician. At this time, we will also provide a reminder to make an appointment with your clinic to see if you could benefit from another injection and **offer you a rebate voucher for your second injection**.		
Province	Postal code			

OnTRACK INSURANCE VERIFICATION SERVICE *(OPTIONAL)*

This service requires us to contact your insurer, your spouse's insurer or your employer and helps find alternate payment options. Complete the information below to participate.

☐ Please contact me in order to receive this service

Group health plan *(patient)*		Group health plan *(spouse)*	
Group insurance or plan number		First and last name	Date of birth MM/DD/YYYY
Card number (usually 20 digits)		Group insurance or plan number	Card number (usually 20 digits)
Insurer name	Employer name	Insurer name	Employer name

INITIAL SURVEY FOR NEW OnTRACK PATIENTS

1. Select which option best describes your situation:

☐ I am considering a SYNVISC® injection in the future ☐ This is my first SYNVISC® injection ☐ This is not my first SYNVISC® injection

2. Please indicate which joint was injected: *Please check all that applies.*

Shoulder ☐ Right ☐ Left ☐ Both | Hip ☐ Right ☐ Left ☐ Both

Knee ☐ Right ☐ Left ☐ Both | Ankle ☐ Right ☐ Left ☐ Both

3. What would you like to gain from your SYNVISC® injection (i.e., objective or goal)? *Please check all that applies.*

☐ Increased mobility ☐ Participate in athletics and sports

☐ Mobility post-injury or surgery ☐ Other

4. In the months before your SYNVISC® injection:

A. How much did you know about managing your OA? *Please select one.*

Very little 1 2 3 4 5 6 7 8 9 10 A lot

B. How often did you help to manage your OA by following:

An EXERCISE PLAN? *Please select one.*

☐ Always or frequently ☐ Occasionally ☐ Never or I did not have an exercise plan

A DIET PLAN? *Please select one.*

☐ Always or frequently ☐ Occasionally ☐ Never or I did not have a diet plan

I have read and understood the information provided in this Form (including the Protection of Personal Information section) and accept to participate in the Program.

X

Signature for enrollment consent

– FOR CLINIC USE ONLY –

Clinic information	Patient injection information *(filled out by clinic)*
Physician name	Please indicate which product was injected: ☐ SYNVISC® 1 x 2 mL ☐ SYNVISC® 3 x 2 mL ☐ Synvisc-One®
Clinic name and address (MD stamp OK here)	Date of injection MM/DD/YYYY
	Product lot number (on the box or sticker inside)

Fax completed form to PharmaCommunications Group Inc. at 1-800-603-3863

6 To be filled out by **the clinic**

7 Indicate which SYNVISC® injection was given, the date of the injection and the product lot number, which is found on the SYNVISC® box.

8 Clinics should:

1) Fax the completed form to 1-800-603-3863

2) Place the form in the patient's file for future reference (optional)

SYNVISC® HYLAN G-F 20 | SYNVISC ONE® HYLAN G-F 20

OnTRACK: supporting you through your OA journey

OnTRACK is a free-of-charge support program for people prescribed SYNVISC®. With this program you will get help navigating your insurance coverage options, you will learn more about OA and you will be able to take an active role in managing your OA.

Need help with insurance coverage?

OnTRACK will help advocate coverage with employers or offer you the option to pay in three equal payments.

1

Enrol

Complete the enrollment form and survey

2

Insurance verification service

Get help navigating your insurance coverage for various OA treatments or choose alternate payment options for SYNVISC®

OnTRACK has helped thousands of Canadians like you take action to manage their OA

Starter kit

Enjoy your SYNVISC®/Synvisc-One® starter kit items, including:

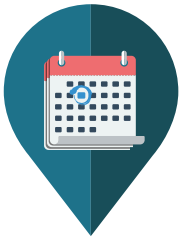
- The Balanced Living Magazine on OA
- Post-injection tips
- A gel pack for cold therapy

3

4

Educational emails

Explore monthly educational emails with tips and tricks on managing OA



5

8-month follow-up

Receive a reminder to think about your next injection appointment and complete a follow-up survey to receive a **$50 rebate** voucher for your next injection (proof of purchase required)

Get your osteoarthritis OnTRACK now by completing the enrollment form

CDN.HYL.17.09.03E 50125484

OnTRACK with SYNVISC®/Synvisc-One®

SANOFI