Claims Department
PO Box 845
Stevens Point, WI 54481-0047
Toll Free: 1-800-295-4010

AIG Claims, Inc. is a wholly owned subsidiary of AIG and provides claims administration for the Group Policy provided with the Sanofi Promise Warranty Program.

Sanofi Promise Warranty Program for CABLIVI® (caplacizumab-yhdp)
WARRANTY CLAIM FORM

(TO BE COMPLETED BY AN AUTHORIZED HOSPITAL REPRESENTATIVE)

CLAIM NO:

If you do not yet have a claim number, leave this section blank upon submission.

IMPORTANT NOTE:

Please complete all sections of this form.
An incomplete form may cause a delay in our assessment of your claim. Please either type your responses or print clearly.

Coverage is provided by New Hampshire Insurance Company, an AIG Company. Coverage is subject to certain terms, conditions, and limitations, including limitations on the amount of coverage.

To enable us to process your claim expeditiously, please return the completed claim form with supporting documents as listed in the subsequent section. Please direct the claim form and all correspondence to:

AIG Claims, Inc.
PO Box 845
Stevens Point, WI 54481-0047
Email: SanofiPromise@aig.com
Fax: 1-715-342-2405
For Questions, please call 1-800-295-4010

All benefits are paid in accordance with the terms and conditions of the Group Policy. The acceptance of this claim form is NOT an admission of liability on the part of Sanofi and/or AIG Claims, Inc. Any documentary proof or report required to process this claim shall be furnished at the expense of the Hospital. *This Group Policy is underwritten by New Hampshire Insurance Company, an AIG Company, and benefits are provided to you as part of the Sanofi Promise Warranty Program.* For details about how AIG collects and uses personal information submitted via this form, please visit https://www.aig.com/privacy-policy.

Documents Required:

- **Signed and completed Warranty Claim Form with proof of purchase evidence**
- **Signed and completed Hospital Declarations and Authorizations Form**
- **Signed and completed Physician Attestation Form**

PATIENT INFORMATION (FOR PHARMACOVIGILENCE REPORTING PURPOSES)		
Patient Initials:	Gender:	Date of Birth (MM/DD/YYYY):

HOSPITAL INFORMATION	
Hospital Name:	Mailing Address (Street, City, State, Zip):
Tax ID Number (TIN):	Hospital ID Number (HIN):

AUTHORIZED HOSPITAL REPRESENTATIVE INFORMATION			
Hospital Representative Name (First, Middle, Last)	Title:		
Department:	Mailing Address, If different than hospital (Street, City, State, Zip):		
Email Address:			
Phone Number:	Fax Number:		
Communications Preferences: How would you like to receive claims status updates? (check all that apply)	Phone	Email	Mail

By requesting for us to communicate with you electronically, you consent to electronic delivery of notices, disclosures, documents and other communications from [AIG Claims, Inc.] via the communications method indicated above in relation to your claim, including leaving voicemails on the phone number indicated above. If applicable, you also agree to check your messages and/or email accounts and to inform [AIG Claims, Inc.] of any changes to the above information. You agree that all notices, disclosures and other communications that we provide to you electronically satisfy any legal requirements that such communications should be in writing.

TREATING PHYSICIAN INFORMATION
Treating Physician Name (First, Middle, Last)
Business Mailing Address, if different than hospital (Street, City, State, Zip):

PRODUCT INFORMATION	
Product Name:	
Product Batch Number:	**Product Dosage:**

CABLIVI CLAIM REASON Please select the reason aTTP/iTTP patient was a non-responder while on CABLIVI [Select ONE]	
☐	**Failure to Reach Initial Clinical Response**: Patient experienced platelet counts <50 x 10^9/L after 4 days of combined treatment with CABLIVI, therapeutic plasma exchange and immunosuppressive therapy* *Maximum of 6 doses
☐	**Exacerbation:** Patient experienced a new drop in platelet count after initial platelet count normalization (>150x10^9/L), necessitating re-initiation of therapeutic plasma exchange after having ruled out any causes for the drop in platelet count other than aTTP/iTTP pathophysiology** **Maximum of 12 doses

CABLIVI CLAIM DETAILS		
Date of Hospital Admission:		
Order Date of ADAMTS13 Test:	Date of Confirmed aTTP/iTTP Diagnosis (ADAMTS13 <10%):	
CABLIVI Route of Administration (initial dose and subsequent dose):	CABLIVI Frequency of Administration:	Number of CABLIVI Doses Administered: (please attach CABLIVI proof of purchase (invoice))

Platelet Levels at aTTP/iTTP Diagnosis and Treatment Initiation	
Platelet Level at Diagnosis [Date]: [Platelet Levels]	Platelet level at Treatment Initiation (if different than date of diagnosis) [Date]: [Platelet Levels]

Platelet Levels During aTTP/iTTP Treatment Please specify the date and platelet levels after each treatment			
[Date]:	☐ TPE + IS*	☐ CABLIVI	[Platelet Level]
[Date]:	☐ TPE + IS	☐ CABLIVI	[Platelet Level]

[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]
[Date]:	❑ TPE + IS	❑ CABLIVI	[Platelet Level]

*TPE + IS = Therapeutic Plasma Exchange and Immunosuppressive Therapy

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