



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: [TradeDataManagement@sanofi.com](mailto:TradeDataManagement@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: [TradeDataManagement@sanofi.com](mailto:TradeDataManagement@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** \_\_\_\_\_  
 GLN # (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 \_\_\_\_\_  
 2<sup>nd</sup> 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
<input type="checkbox"/> Clinic	<input type="checkbox"/> Mail Order Pharmacy	<input type="checkbox"/> Public Corporation
<input type="checkbox"/> Hospital	<input type="checkbox"/> Department of Defense	<input type="checkbox"/> Private Corporation
<input type="checkbox"/> Physician	<input type="checkbox"/> Veteran Facility (VA)	<input type="checkbox"/> Partnership
<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Independent Retail	<input type="checkbox"/> Limited Liability Corporation
<input type="checkbox"/> Specialty Pharmacy	<input type="checkbox"/> Chain Retail	<input type="checkbox"/> Sole Proprietor
<input type="checkbox"/> 340B Entity; 340B#	<input type="checkbox"/> Other (Please describe below)	<input type="checkbox"/> 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	<input type="checkbox"/> Yes
Are there any pending lawsuits against the business?	No	<input type="checkbox"/> Yes
How would you like to receive invoices?	<input type="checkbox"/> EDI	<input type="checkbox"/> Email <input type="checkbox"/> Paper
What is your preferred method of payment?	<input type="checkbox"/> EFT	<input type="checkbox"/> Check <input type="checkbox"/> 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	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$100,000	<input type="checkbox"/> 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: [TradeDataManagement@sanofi.com](mailto:TradeDataManagement@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** \_\_\_\_\_  
GLN # (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** \_\_\_\_\_  
GLN # (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.**