Supplemental Address Form*

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