REIMBURSEMENT SERVICES AND PATIENT ASSISTANCE PROGRAM

P.O. Box 8256
Somerville, NJ 08876
Phone: (888) 632-8607
Fax: (888) 875-9951

To ensure you receive the optimal benefit from the program,
advance discharge planning is recommended.

Reimbursement Services Instructions:

- Please complete the application in its entirety.
- Please have the patient sign the **Patient Certification and Authorization to Disclose Information** section.
- **Fax the application** to: **(888) 875-9951**

PAP Instructions:

- Please complete the application in its entirety.
- Please have the patient sign the **Patient Certification and Authorization to Disclose Information** section.
- Please have the practitioner sign the **Practitioner Statement Section**.
- **Fax the application** with completed therapy information (RX information) for up to a maximum 3-month supply to: **(888) 875-9951**

Program Eligibility:

- Patient must be a resident of the United States.
- Patient cannot have or qualify for any government prescription coverage for Lovenox such as, Medicaid, Veteran's Administration, or any state or local programs. Patient cannot have Medicare Part D prescription coverage. If the patient has Medicare Part D but is still having a problem affording their medication, please apply as sanofi-aventis may be able to help.
- Patient cannot have any private prescription drug coverage.
- Lovenox must be administered for outpatient use only.
- Patient's total yearly household income must be at or below the limits shown in the chart below:

Household Size	Total Yearly Household Income	Total Monthly Household Income
1	**$ 27,225**	**$ 2,269**
2	**$ 36,775**	**$ 3,065**
3	**$ 46,325**	**$ 3,860**
4	**$ 55,875**	**$ 4,656**
5	**$ 65,425**	**$ 5,452**
6+	**$ 74,975**	**$ 6,248**

Please contact the Lovenox hotline or visit www.Lovenox.com for full prescribing information, including boxed WARNING.

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Patient Information

Name of Patient

Address

City State Zip

( ) Male Female
Phone Number Gender (circle one)

Date of Birth SS#

1. Does the patient have or qualify for prescription drug coverage in any government program? YES ❑ NO ❑
2. Does the patient have or qualify for prescription drug coverage in any private program? YES ❑ NO ❑
3. Is the patient a U.S. resident? YES ❑ NO ❑
4. What is the total **ANNUAL** household income (including social security, pension benefits, etc: $_____
5. How many people are in the patient's household? 1❑ 2❑ 3❑ 4❑ 5❑ 6+❑

Insurance Information ❑ **Please check here if requesting Reimbursement Investigation Only [no PAP]**

Primary Insurance ****Copies of Insurance Cards are preferred****

Name Policy # Group #

( )
Phone Number Effective Date

Subscriber's Name Date of Birth

Address

City State Zip

Secondary Insurance

Name Policy # Group #

( )
Phone Number Effective Date

Subscriber's Name Date of Birth

Address

City State Zip

Therapy and Diagnosis Information **Please contact the Lovenox hotline or visit www.Lovenox.com for full prescribing information, including boxed WARNING**

Strength Dose Sig.

Quantity Length of Therapy

Primary Diagnosis (ICD9 code plus description)

Secondary Diagnosis (ICD9 code plus description)

Facility Contact Name [who we should call concerning this request]

( ) ( )
Phone Number Fax Number

Facility and Treatment Information ❑ **Shipping Address**

Facility Name Facility DEA#

Address

City State Zip

( )
Phone Number NPI#

Surgery Date Discharge Date

Patient Certification and Authorization to Disclose Information

Patient Name:_____ states that the information and documents provided in connection with this application are complete and accurate and that I meet all eligibility criteria for participation in the program, including income limits. I agree to immediately inform a Program representative and my Doctor/Healthcare Provider if my income or insurance status changes during the course of my participation in this Program. I understand that application to the Program does not guarantee that assistance will be obtained, and (1) participation in this Program is subject to approval under Program guidelines, (2) approval is for a limited period and (3) periodic re-application is required for continued participation. I understand that my information will be used by the Program Sponsor, sanofi-aventis, U.S., the sanofi-aventis Foundation for Patient Assistance and authorized third party agents involved in administration of this Program, (collectively "Program Sponsor"), for purposes of determining my participation in, and administering, the Program, which may include contacting me as well as my Doctor/Healthcare Provider, office/hospital staff, insurer (public/private) or others. I authorize and consent to release of identifiable information about me including medical, financial and insurance records and information as required for participation in the Program. My authorization includes release of information relating to treatment for substance abuse, psychiatric and/or medical conditions, and HIV test results or diagnosis, if required. I understand that identifiable information about me will be kept confidential and will not be further used or disclosed except to administer the Program, or as required by law. I understand that information I authorize to be disclosed may be re-disclosed and no longer protected by Federal privacy regulations. I agree that this authorization is voluntary and that I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment but I will not be able to participate in this Program. Unless revoked this authorization shall remain in effect throughout my participation in the Program, including subsequent re-application as required. I may withdraw this authorization at any time by written notification to my Doctor/Healthcare Provider; however withdrawal of authorization will terminate my participation in this Program and will not affect information already disclosed. I further authorize use of my Social Security number for identification and recordkeeping purposes. I hereby release, for myself and on behalf of my successors and assigns, Program Sponsor (collectively), their officers, directors, employees, and agents from any and all claims or liability arising from their conduct pursuant to this authorization or the use or disclosure of information relating to my Program participation as long as such use or disclosure is made in good faith and without malice and is consistent with this authorization. I understand that sanofi-aventis U.S. and the sanofi-aventis Foundation for Patient Assistance reserve the right at any time and without notice to modify or change eligibility criteria, or modify or discontinue this Program.

PATIENT'S SIGNATURE **Date**

Licensed Prescriber Information ❑ **Shipping Address**

Name Specialty

Address (PRODUCT SHIPMENT PURPOSES) NPI#

City State Zip

( ) ( )
Phone Number Fax Number

State License Number Professional Designation (MD, DO, etc)

( )
Office Contact Name Contact Phone Number

To the best of my knowledge the information contained in this application is complete and accurate and this patient has no prescription insurance coverage either private or public (e.g. Medicaid), and meets the required income limits for participation in this Program. If I become aware of a change in income or insurance status that may effect Program participation of this patient, I will alert Program Sponsor. I understand that sanofi-aventis U.S. and the sanofi-aventis Foundation for Patient Assistance reserve the right to modify or terminate this program at any time without notice. I attest that I am not on the HHS/OIG list of Excluded Individuals. My signature certifies that prescription products received from this Program will be used for the above named patient only and will not be resold nor offered for sale, trade or barter and will not be returned for credit. I agree to participate in any recall of the product initiated by the manufacturer.

Licensed Doctor or other Healthcare Professional (No stamps) **Date**