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 legal 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:

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Total Yearly Household Income</th>
<th>Total Monthly Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$27,075</td>
<td>$2,256</td>
</tr>
<tr>
<td>2</td>
<td>$36,425</td>
<td>$3,035</td>
</tr>
<tr>
<td>3</td>
<td>$45,775</td>
<td>$3,815</td>
</tr>
<tr>
<td>4</td>
<td>$55,125</td>
<td>$4,594</td>
</tr>
<tr>
<td>5</td>
<td>$64,475</td>
<td>$5,373</td>
</tr>
<tr>
<td>6+</td>
<td>$73,825</td>
<td>$6,152</td>
</tr>
</tbody>
</table>
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 legal 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

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 Name  Address

Facility DEA#