RILUTEK CONTINUITY PROGRAM
P.O. Box 373
Somerville, NJ 08876
Phone: (800) RILUTEK
(800) 745-8835
Fax: (866) 217-7178

Instructions:

- Please complete the application in its entirety.
- Please be sure to have the patient sign the **Patient Statement Section**.
- Please be sure to have the Practitioner sign the **Practitioner Statement Section**.
- Completion of the Insurance Information Section is not required if submitting front and back copies of any/all insurance cards.
- **Mail application to Po Box 373 or Fax the to: (866) 217-7178**
- **If reimbursement is not obtained, applications will be forwarded to NORD for Patient Assistance Evaluation [additional information may be required by NORD]**

Patient Assistance Program Eligibility:

- Patient must be a legal resident of the United States.
- Eligibility is determined solely by medical and financial criteria. All eligibility decisions are made by NORD.

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sanofi-aventis U.S. Patient Assistance Foundation
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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 legal U.S. resident? YES ❑ NO ❑
4. What is the total **ANNUAL** household income, including social security and pension benefits? $ _____ ANNUAL
5. Household size _____

Primary Insurance

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

PLEASE PROVIDE
Therapy Information

Strength | Dose | Sig.

Quantity | Days Supply

Diagnosis Information

Primary Diagnosis (ICD9 code plus description)

Secondary Diagnosis (ICD9 code plus description)

Contact [who we should call concerning this request]

Contact Name

( ) | ( )
Phone Number | Fax Number

Patient Statement

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to sanofi-aventis U.S. and its agents, all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in the Rilutek Patient Assistance Program. I also authorize sanofi-aventis U.S. and its agents to disclose all such records and information to any of the persons or entities listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I verify that the information provided in this application is complete and accurate. I understand that sanofi-aventis U.S. reserves the right at any time and without notice to modify the application or modify or discontinue this program and the related eligibility criteria. I authorize sanofi-aventis U.S. to use my Social Security number for identification purposes and record keeping only. I have read, understand and agree to all of the above.

Patient's Signature | Date

Licensed Prescriber Information ❑ Shipping Address

Name | Specialty

Address | Provider ID#

City | State | Zip

( ) | ( )
Phone Number | Fax Number

DEA# | Professional Designation (MD, DO, etc)

( )
Office Contact Name | Contact Phone Number

Licensed Prescriber Statement

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage for Rilutek, including all public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that sanofi-aventis U.S. reserves the right to modify or terminate this program at any time. My signature certifies that these goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that sanofi-aventis U.S. reserves the right to recall the product when necessary.

Licensed Prescriber's Signature | Date