sanofi-aventis Patient Assistance Foundation
sanofi-aventis U.S. Patient Assistance Program
P.O. Box 759 Somerville, NJ 08876
Phone (800) 221-4025
Fax (866) 734-7372

Information about the sanofi-aventis U.S. Patient Assistance Foundation Program

- Once you qualify, you may be able to receive free medication for up to 12 months.
- Up to a 90 day supply of medication will be sent to your healthcare practitioner. You will be able to refill your order every 3 months until the 12 months is complete.
- Call 800-221-4025 and use the automated system to refill your medication.

Instructions for completing the application

1. Fill out all of the information in the application and sign on the line that says "Patient's signature".
2. Take the application to your physician. Have your physician sign on the line that says "Original Signature of Licensed Practitioner (No stamped signatures)".
3. Attach a copy of your Federal Tax Return. If you do not file taxes please include another proof of yearly income such as paystubs, a bank statement of deposit, or an attested letter describing your yearly income.
4. Have the physician fill out the Prescription Section below or include an original prescription of a sanofi-aventis U.S. brand name product. You can see a complete list of available products by calling the 800 number above.
5. Finally, mail or fax the application, prescription (if not using Prescription Section on the application), and photocopy of Federal income tax return (or other proof of income) to the address or fax number above.

Patient Assistance Program Eligibility

- Patient must be a legal resident of the United States.
- Patient cannot have or qualify for any government prescription coverage 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.
- 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	$27,075	$2,256
2	$36,425	$3,035
3	$45,775	$3,815
4	$55,125	$4,594
5	$64,475	$5,373
6+	$73,825	$6,152

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PATIENT SECTION – The patient or his/her legal representative must complete this section

NAME:	(First)	(Middle)	(Last)
ADDRESS:			
CITY:		STATE:	ZIP CODE:
DATE OF BIRTH:		PHONE NUMBER:	Gender: M ☐ F ☐
DO YOU HAVE OR QUALIFY FOR A PUBLIC OR PRIVATE PRESCRIPTION DRUG BENEFIT OR INSURANCE PROGRAM? Medicaid: YES ☐ NO☐ Medicare Part D: YES ☐ NO☐ Private: YES☐ NO☐ Veteran's Administration: YES ☐ NO☐ Other State or Local Programs: YES☐ NO☐			
ARE YOU A LEGAL U.S. RESIDENT? YES ☐ NO☐ Are you currently a member of Together Rx? YES☐ NO☐ If not, please describe your residency status:			
SOCIAL SECURITY NUMBER:_____-_____-_____ If you do not have a Social Security number, please provide another form of identification such as a Green Card number, Visa, etc.			
WHAT IS YOUR TOTAL ANNUAL HOUSEHOLD INCOME? (Including Social Security, Pension income, etc.): $			
HOW MANY PEOPLE ARE THERE IN YOUR HOUSEHOLD? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ ☐			

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 PRACTITIONER SECTION – The licensed practitioner must complete this section

NAME:		PROFESSIONAL DESIGNATION: (MD, DO, ETC.):
OFFICE ADDRESS: (No P.O. Box)		
CITY:	STATE:	ZIP CODE:
STATE LICENSE NUMBER:	OFFICE CONTACT PERSON:	
OFFICE PHONE #:	OFFICE FAX #:	

PRESCRIPTION INFORMATION

Product Name:	Strength:	Quantity Per Day:
Product Name:	Strength:	Quantity Per Day:

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 DR OR OTHER HCP (No stamps) **Date**