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 [except for the last section marked "For Patient Assistance Program Only"].
- Please have the patient sign the **Patient Statement Section**.
- **Fax the application** to: **(888) 875-9951**

PAP Instructions:

- Please complete the application in its entirety.
- Please have the Patient sign the **Patient Statement 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 cannot have or qualify for any prescription coverage for Lovenox, including all federal, state and local programs.
- Patient must be a legal resident of the United States.
- Lovenox must be administered for outpatient use only.
- Patient's total annual household income must be **below** the sanofi-aventis U.S. Poverty Level. See chart below.

Household Size	Total Annual Household Income	Total Monthly Household Income	Please Note:
1	$20,800	$1,733	While sanofi-aventis U.S. will make every effort to grant aid when needed, this program is limited to available resources and may be discontinued or revised at any time.
2	$28,000	$2,333	
3	$35,200	$2,933	
4	$42,400	$3,533	
5	$49,600	$4,133	
6+	$56,800	$4,733	

sanofi aventis

LOVENOX® (enoxaparin sodium injection)

REIMBURSEMENT SERVICES AND PATIENT ASSISTANCE PROGRAM

Phone: (888) 632-8607 Fax: (888) 875-9951

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 _____

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

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

IF REQUESTING PATIENT ASSISTANCE

PLEASE PROVIDE

Therapy Information

Strength Dose Sig.

Quantity Length of Therapy

1/10/08

Diagnosis Information

Primary Diagnosis (ICD9 code plus description)

Secondary Diagnosis (ICD9 code plus description)

Facility Contact [who we should call concerning this request]

Contact Name

( ) ( )

Phone Number Fax Number

Facility and Treatment Information ❑ Shipping Address

Facility Name Facility DEA#

Address

City State Zip

( )

Phone Number Provider ID#

Surgery Date Discharge Date

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 Lovenox Reimbursement Services and 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

FOR PATIENT ASSISTANCE PROGRAM ONLY

Licensed Prescriber Information ❑ Shipping Address

Name Specialty

Address (PRODUCT SHIPMENT PURPOSES) Provider ID#

City State Zip

( ) ( )

Phone Number Fax Number

DEA# Professional Designation (MD, DO, etc)

( )

Office Contact Name Contact Phone Number

If DEA# is not available, please attach a copy of your state license.

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 Lovenox, 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