Reset Form

sanofi-aventis
Patient Assistance Application (PAP)
Hyalgan® (sodium hyaluronate) Application

***** Return COMPLETED APPLICATION, PRESCRIPTION, & DISCLOSURE FORM to the address or fax listed below.**

PHYSICIAN NAME_____ **Date**_____

Address_____

City_____**State**_____ **Zip**_____

Daytime Phone # ( )_____ **Fax #** _____

PATIENT NAME_____ **Phone # ( )**_____

Address_____ **Social Security #**_____

City_____ **State**_____ **Zip**_____

Product Requested_____**Hyalgan**_____ **Date Treatment to Begin**_____

Qualified patients must meet the following criteria:

1. The patient's income must not exceed 200% of the federal poverty level (see attached).

2. The patient cannot be enrolled or qualify to be enrolled in any form of medication reimbursement program, including city, county, state or federal funded programs or any private insurance plans.

I certify that the patient I am sponsoring for enrollment in the sanofi-aventis Hyalgan Patient Assistance Program meets the qualifications listed above.

I certify that no third party (including Medicare, Medicaid, other federal or state programs, private insurance, the patient or any other individual) will be billed for the free goods provided under the sanofi-aventis Hyalgan Patient Assistance Program.

_____ _____
Physician's Signature **Date**

_____ _____
Print Name **State License #**

_____
MD Tax Exempt #

***** Hyalgan Reimbursement Hotline**
c/o Lash Group
PO Box 1074
San Bruno, CA 94066
1-800-992-9022
1-877-366-0584 (Fax)

PAP Authorization

AUTHORIZATION TO DISCLOSE INFORMATION ABOUT ME IN THE PATIENT ASSISTANCE PROGRAM

sanofi-aventis offers a Patient Assistance Program to help patients who qualify afford their medicines. I understand that sanofi-aventis needs certain information about me to see if I qualify under the Program for assistance in paying for its product. I request and authorize my doctor, _____ ("Doctor") and my health insurance company _____ ("Insurer") to give sanofi-aventis, including representatives who work on behalf of sanofi-aventis in this Program, information about my health care treatment and insurance coverage. The type of information that may be given to sanofi-aventis includes information that identifies me like my name, address, social security number, financial information, diagnoses, prior treatments, and information about my health plan benefits.

I know that I need to sign this authorization to take part in this Patient Assistance Program. If I do not sign this authorization, my decision will not affect my ability to obtain treatment or to seek payment for treatment. I also know that I can cancel this authorization at any time by writing to Doctor or sanofi-aventis Doctor's mailing address is _____ _____. If I cancel this authorization, then Doctor and Insurer will stop providing sanofi-aventis with information about me. However, I cannot cancel actions that they have already taken by relying on my authorization.

I understand that once Doctor and Insurer give sanofi-aventis information about me based on this authorization, federal privacy laws may not prevent sanofi-aventis from further disclosing my information. However, Insurer has agreed that it will only use information about me to determine my eligibility for this program, to administer the program, and to account for my withdrawal if I decide to stop participating in this program. I also understand that signing this authorization does not guarantee that I will be able to get the product _____ from sanofi-aventis at a reduced or no cost. This authorization is good for as long as I participate in the sanofi-aventis Patient Assistance Program.

A copy of this signed form will be sent back to me for my records.

Patient or Personal Representative of Patient

_____ **Date** _____

Signature

_____ _____

Name (*Please Print*) **Authority to sign on behalf of Patient (*if applicable*)**

sanofi-aventis HYALGAN PATIENT ASSISTANCE PROGRAM

Income Restrictions Based on Federal Poverty Level

Total # in Household	Poverty Level 48 states; Alaska; Hawaii	PAP Income Level = 200% Poverty 48 States	Alaska	Hawaii
1	$ 10,210; 12,770; 11,750	$20,420	25,540	23,500
2	$ 13,690; 17,120; 15,750	$27,380	34,240	31,500
3	$ 17,170; 21,470; 19,750	$34,340	42,940	39,500
4	$ 20,650; 25,820; 23,750	$41,300	51,640	47,500
5	$ 24,130; 30,170; 27,750	$48,260	60,340	55,500
6	$ 27,610; 34,520; 31,750	$55,220	69,040	63,500
7	$ 31,090; 38,870; 35,750	$62,180	77,740	71,500
8	$ 34,570; 43,220; 39,750	$69,140	86,440	79,500
for each additional	$ 3,480; 4,350; 4,000	$ 6,960	8,700	8,000

To be eligible for the PAP, household income cannot exceed 200% of the federal poverty level for the most recent available year.

SOURCE: *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148