

Patient Confidentiality Release Form
The PACT+SM Program
Phone: 800-996-6626
Fax: 800-996-6627
E-mail: ePACT@access2health.com



The PACT+ Program is a reimbursement and product support program sponsored by sanofi-aventis, a pharmaceutical manufacturer. We work with patients, physicians, and healthcare providers to

- Understand your insurance coverage options
- Access benefits available through your insurance plan
- Appeal an insurance denial when possible
- Investigate coverage through other sources when necessary

In order for us to gather this information and advocate for reimbursement for your physician’s prescribed course of treatment, we require your signature below, certifying that you understand that we are working on your behalf. Please read the information below carefully. When you understand it, please sign the form, fax it to the number above, and keep a copy for your records.

I, _____, hereby authorize the following agents:

- | | |
|--|------------------------------|
| • My insurance company | • Employer |
| • Prepayment organizations | • Physician |
| • PACT+ Program and Reimbursement Services Group representatives | • sanofi-aventis |
| • Government agencies | • Other healthcare providers |

to collect and/or release all medical, financial, and patient information with respect to myself, which may have bearing on the benefits payable for services or products provided through the healthcare provider under any plan providing benefits or services, including (without limitations) the dollar balance of benefits remaining under any applicable lifetime maximum benefits provisions, or which may have bearing on my medical condition or compliance with therapy. I authorize the PACT+ Program and/or its agents, including Reimbursement Services Group representatives, to release such information to any of the people or entities listed above for the purpose of seeking reimbursement assistance. I understand that the information identifying me will not be used for any purpose other than described above unless I have given my written consent.

I have read, understand, and agree to all of the above. A faxed copy of this agreement may be used as though it were the original. This release will be effective until revoked by me in writing.

 Print Patient or Guardian Name

 Signature of Patient or Guardian

 Date

 Print Witness Name

 Signature of Witness

 Date

PACT+ Program
 100 Grandview Road, Suite 210
 Braintree, MA 02184



Dear Healthcare Professional:

Thank you for inquiring about the PACT+SM Program. Attached is a qualification form for your Anzemet[®] (dolasetron mesylate) injection/tablets patient with CINV.

PLEASE TAKE A MOMENT TO READ THE FOLLOWING IMPORTANT INSTRUCTIONS.

1. Complete and sign the original qualification form. You will note the bottom half of the form acts as a prescription and must be completed carefully.
2. Please ensure you have obtained the necessary consent from your patient permitting you to divulge this information.
3. Fax the completed application to PACT+ at 1-800-996-6627 and retain a copy for your records.

PACT+ will review the form and confirm your patient's eligibility within 48 hours of receipt. Eligible patients will be granted up to a 3-month course of Anzemet[®] at no cost. Upon initial eligibility, the first cycle of therapy will be shipped directly to the physician.

Sanofi-aventis reserves the right to verify all information provided, suspend participation when inadequate information is provided, and limit or suspend enrollment based on available resources. If you have any questions, or would like to enroll other patients, please do not hesitate to contact us at 1-800-996-6626, Monday through Friday, 8:30 AM to 6:00 PM ET.

Sincerely,

The PACT+ Program

PACT+SM Contact Information

Phone: 1-800-996-ONCO (6626)

Fax: 1-800-996-6627

E-mail: ePACT@access2health.com

Hours of operation: M–F 8:30 AM–6:00 PM ET

www.AventisOncology.com

Anzemet[®] CINV Patient Assistance Program

100 Grandview Road, Suite 210

Braintree, MA 02184



sanofi aventis
Because health matters

**The PACT+SM Program for
Anzemet[®] (dolasetron mesylate) injection/tablets
CINV Patient Assistance Program Qualification Form
For Information: 800-996-ONCO (6626)
E-mail: ePACT@access2health.com**



Instructions: Completion of this form in its entirety, including the physician's signature, is required to process this application. Information supplied on this form will be held in strict confidence and will only be used for the administration of this program.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____
 Address: _____ Social Security #: _____
 City, State ZIP: _____ Diagnoses: _____
 Patient Phone #: _____ ICD-9s: _____
 Gender: _____ Dates of Service: _____

To enroll in this program, the patient must be a US resident and meet one of the following insurance status categories. Check each item as applicable.

- Uninsured
- Insurance with drug coverage
- Annual limit reached
- Lifetime limit reached
- Insurance without coverage for Anzemet[®]
- Insurance with denied coverage for Anzemet[®]
(A copy of the denial must be included with the application.)
- Medicaid ineligible

Total # of People in the Household: _____
 Total Annual Income: _____
 Insurer: _____
 Policy ID #: _____
 Group: _____
 Insurance Phone #: _____

Should the PACT+ Program have additional questions or require further information, may we contact the patient directly?

Yes No

PHYSICIAN INFORMATION

Physician Name: _____
 Physician DEA #: _____
 Address: _____
 City, State ZIP: _____
 Phone #: _____
 Fax #: _____
 Office Contact Name: _____
 Office Contact Phone #: _____
 Office E-mail Address: _____

PRESCRIBING INFORMATION

iv Dosage: _____ mg q _____ × _____
 Oral Dosage: _____ mg q _____ × _____
 Sig: _____

SHIPPING INFORMATION

Attention: _____
 Address: _____
 City, State ZIP: _____
 Telephone: _____

I certify that all other avenues of financial assistance for acquiring Anzemet[®] have been exhausted and hereby give permission for the information disclosed on this application to be released to the PACT+ Program. The information submitted on this form is true and complete to the best of my knowledge.

Physician signature (required): _____ Date: _____

Please fax this completed form to the PACT+ Program at 800-996-6627.

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