



Patient Assistance Program
P.O. Box 759 Somerville, NJ 08876
(800) 221-4025

Patient Section\* - The patient or his/her legal guardian must complete this section.
NAME: SOCIAL SECURITY#:
ADDRESS:
CITY: STATE: ZIP CODE:
DATE OF BIRTH: PHONE NUMBER:
DOES THE PATIENT HAVE OR QUALIFY FOR PRESCRIPTION COVERAGE IN ANY GOVERNMENT PROGRAMS?
DOES THE PATIENT HAVE MEDICARE PART D PRESCRIPTION COVERAGE?
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE IN ANY PRIVATE PROGRAMS?
IS THE PATIENT A LEGAL U.S. RESIDENT?
WHAT IS THE TOTAL ANNUAL HOUSEHOLD INCOME INCLUDING SOCIAL SECURITY & PENSION BENEFITS? \$ [ANNUAL]
HOW MANY RESIDENTS ARE THERE IN YOUR HOUSEHOLD? (Check box)

I verify that the information provided in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for medication. I understand that sanofi-aventis reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I understand that I am expected to seek any available state or government assistance before reapplying to the sanofi-aventis Patient Assistance Program. I authorize sanofi-aventis to use the information on this application to process my request for medication from the sanofi-aventis Patient Assistance Program and authorize the use of my Social Security number for identification purposes and record keeping.

Patient or Legal Guardian'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:
DEA#: (If you do not have a DEA#, attach a copy of your state license)
CONTACT PERSON IN OFFICE: OFFICE PHONE #:

I represent that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient has no prescription insurance coverage for the requested medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that sanofi-aventis reserves the right to modify or terminate this program at any time. My signature certifies that goods received from sanofi-aventis are for the use of the above named patient only. 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 reserves the right to recall the product when necessary.

Original Signature of License Practitioner (No stamped signatures)

Date

\*IF ALL INFORMATION IS NOT CLEARLY AND COMPLETELY FILLED OUT, THIS FORM WILL NOT BE PROCESSED
ATTACH A PRESCRIPTION AND MOST RECENT FEDERAL TAX RETURN OR OTHER PROOF OF INCOME.
A NEW APPLICATION AND PRESCRIPTION MUST BE SENT IN TO RECEIVE A RE-ORDER.
PROOF OF INCOME IS ONLY NECESSARY ANNUALLY.

DEA # \_\_\_\_\_  
LIC. # \_\_\_\_\_

Date \_\_\_\_\_

**Patient**

Name \_\_\_\_\_

DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

**Rx**

Qty:

Sig:

\_\_\_\_\_  
( X ) Dispense as Written, signed by provider

Refill \_\_\_\_\_ times

VOID if Not Signed by Provider