



Instructions:

- ☛ Patient and Practitioner Section must be filled out completely.
- ☛ **ATTACH A PHOTOCOPY OF THE PATIENT'S MOST RECENT FEDERAL TAX RETURN.** If the patient does not file taxes, please attach other proof of annual income.
- ☛ **ATTACH AN ORIGINAL PRESCRIPTION** up to a maximum **3-month supply** of a sanofi-aventis brand name product you are requesting.
- ☛ Mail or fax application, prescription, and photocopy of Federal income tax return to the following address:

sanofi-aventis Patient Assistance Program
P.O. Box 759
Somerville, NJ 08876
Fax#: (866) 734-7372
- ☛ Please allow 4 weeks for processing and delivery of a 90-day supply of medication to the practitioner's office for approved patients.
- ☛ Both the patient and practitioner will be advised in writing of any denied requests.
- ☛ All incomplete applications will be sent to either the patient or practitioner for completion.

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.
- ☛ Patient cannot have any private prescription coverage such as a HMO or PPO.
- ☛ Patient's total annual household income must be **below** the sanofi-aventis Poverty Level. *See chart below.*

<u>Household Size</u>	<u>Total Annual Household Income</u>	<u>Total Monthly Household Income</u>
1	\$19,600	\$1,634
2	\$26,400	\$2,200
3	\$33,200	\$2,767
4	\$40,000	\$3,334
5	\$46,800	\$3,900
6+	\$53,600	\$4,467

Please Note: While sanofi-aventis 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.

The following products are available in the strengths indicated below to patients on the sanofi-aventis Patient Assistance Program:

Allegra®	30mg, 60mg or 180mg Tablets	Btl of 100	Kerlone®	10mg or 20mg Tablets	Btl of 100
Allegra D®	60mg Tablets	Btl of 100	Lantus®	100units/mL	Pk of 4 or 10
Amaryl®	1mg, 2mg or 4mg Tablets	Btl of 100	Mytelese®	10mg Caplets	Btl of 100
Apidra®	100units/mL	Pk of 4 or 10	Nasacort® AQ	16.5g Nasal Spray	1 canister
Aralen®	500mg Tablets	Btl of 25	pHisoHex®	5oz	Box of 1
Arava®	10mg or 20mg Tablets	Btl of 30	Plaquenil®	200mg Coated Tablets	Btl of 100
Cantil®	25mg Tablets	Btl of 100	Primaquine Phosphate	26.3 Tablets	Btl of 100
DDAVP®	0.1mg or 0.2mg Tablets	Btl of 100	Skelid®	200mg Tablets	Box of 56
DDAVP® Injection	4mcg/mL	1 x 10mL vial	Uroxatral®	10mg Tablets	Btl of 100
DDAVP® Rhinal Tube	10mcg/mL	2.5mL vial	Zephiran®	Chloride Aqueous Sol	8oz Btl
Drisdol®	50,000 I.U. or 200 I.U.	Btl of 50 2oz	Zephrex LA®	Tablets	Btl of 100
Kayexalate®	Powder	1lb. Jar			

For your convenience, you may request product re-orders 60 days after your most recent order by sending in a new, completed application and prescription.

It is not necessary to provide proof of income with each application during your eligibility year unless there is a change in circumstance.



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? <i>(This includes Medicaid, Veteran's Administration and any other state or local programs.)</i>		
	YES	NO
DOES THE PATIENT HAVE MEDICARE PART D PRESCRIPTION COVERAGE?		
	YES	NO
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE IN ANY PRIVATE PROGRAMS? <i>(This includes coverage through any private insurance, HMOs, or PPOs.)</i>		
	YES	NO
IS THE PATIENT A LEGAL U.S. RESIDENT?		
	YES	NO
WHAT IS THE TOTAL ANNUAL HOUSEHOLD INCOME INCLUDING SOCIAL SECURITY & PENSION BENEFITS? \$ [ANNUAL]		
HOW MANY RESIDENTS ARE THERE IN YOUR HOUSEHOLD? (Check box) 1 2 3 4 5 6+		

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: <i>(No P.O. Box)</i>		
CITY:	STATE:	ZIP CODE:
DEA#:	<i>(If you do not have a DEA#, attach a copy of your state license)</i>	
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.