

APPLICATION INSTRUCTION GUIDE

To ensure that you maximize the full range of services for the MULTAQ Patient Support Program, we have provided this instructional sheet for your convenience. For additional information on how the Program can assist your office and patients, you may reach us at:

Phone: 1-888-968-5827
Fax: 1-866-910-9024

P.O. Box 1074
San Bruno, CA 94066

INSURANCE COVERAGE VERIFICATION

- Please complete sections I, II, III, IV and VI of the Enrollment Form.
 - Please note that for insurance coverage verification, we do not require the patient's income information.
 - Please indicate the provider Tax ID, NPI, and State License# in Section VI.
- Indicate if we may contact your patient regarding Additional Patient Support Services by checking off the appropriate box on Section V.
- Please have the patient sign the Patient Authorization Forms (page 4).
- Submit the application and authorizations form (pages 2–4) via fax: 1-866-910-9024.

ADDITIONAL PATIENT SUPPORT SERVICES

What checking "Yes" really means: If the "Yes" box is checked in Section V, a reimbursement administrator will contact your patient to help identify additional services and resources provided by other organizations which may include, but are not limited to:

Co-Pay Assistance
Patient Education and Adherence Program

Patient Advocacy Support
Other

PATIENT ASSISTANCE PROGRAM (PAP) ELIGIBILITY CRITERIA

- Please complete sections I, II, III, V, and VI of the Enrollment Form.
- Patient must be a US citizen or resident, with a Social Security Number.
- Patient must be under the care of a licensed healthcare provider who is authorized to prescribe, dispense, and administer medicine in the US.
- Patient must meet the appropriate financial criteria:
 - Annual household income of $\leq 250\%$ of current Federal Poverty Level (FPL)
- Submit the application and authorizations form (pages 2–4), plus patient income documentation via fax or mail.

Please Note: PAP eligibility begins at the time of approval and continues for up to 1 year. Practice will receive an initial three month supply of product, and a refill/reorder form must be completed for subsequent PAP shipments within the 12 month period.

PAP INCOME DOCUMENTATION

MULTAQ Patient Support Program accepts the below forms of household income documentation:

- Copy of most recent U.S. Income Tax Return, IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040PR, or
- Copy of W-2, or
- Copy of most recent Social Security/Disability Award Letter, Benefit Statement, monthly check or 1099, or
- Copy of most recent pay stub plus most recent U.S. Income Tax Return, or
- Copy of most recent Social Security Statement.

Please Note: The MULTAQ Patient Support Program reserves the right to contact the patient if clarification is needed.

Please Note: In order to process this application, this form needs to be completed as outlined on the instruction sheet. Patient and Prescriber signatures are required. Information supplied on this form will be held in strict confidence and will only be used for the administration of this program.

SECTION I: Patient Information

Patient Name: _____ **Date of Birth:** _____
Address: _____ **Social Security #:** _____ - ____ - ____
City, State, ZIP: _____ **Age:** _____
Patient Phone #: (____) _____ - _____ **Gender:** _____
*** Total Yearly Income:** _____ **Total # of people in the household:** _____

* **NOTE:** Annual household income is not required for insurance coverage verification. Income documentation must be submitted for patient assistance (PAP) requests.

SECTION II: Product and Prescribing Information

MULTAQ® (dronedarone) Tablets **Dosage:** _____ **Frequency:** _____
ICD-9/Diagnosis: _____

SECTION III: Insurance Coverage Verification

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Uninsured | <input type="checkbox"/> Medicare Part D coverage | <input type="checkbox"/> Insured with drug coverage | <input type="checkbox"/> Annual limit reached |
| <input type="checkbox"/> Medicaid ineligible | <input type="checkbox"/> Insurance with denied coverage | <input type="checkbox"/> Insurance without coverage | <input type="checkbox"/> Lifetime limit reached |

SECTION IV: Insurance Information

Check here for Insurance Coverage Verification only (no income information or documentation is required).

Primary Insurance:

Insurance: _____ **Insurance Phone #:** (____) _____ - _____
Policy#: _____ **Group#:** _____

Secondary Insurance:

Insurance: _____ **Insurance Phone #:** (____) _____ - _____
Policy#: _____ **Group#:** _____

I certify that to the best of my knowledge, information, and belief, that the patient I am sponsoring for enrollment in the MULTAQ Patient Support Program meets the qualification listed above. If I become aware of a change in income or insurance status that may effect program participation of this patient, I will alert the MULTAQ Patient Support Program.

I certify that no third party (including Medicare; Medicaid; other Federal, State, or local programs; private insurance, the patient or any other individual) will be billed for the free goods provided under the MULTAQ Patient Support Program.

SECTION V: Additional Patient Support Services

May the MULTAQ Patient Support Program contact the patient directly for referrals to additional services/resources? Y N
 Please mark which services/resources your patient may be interested in:

- Co-Pay Assistance Patient Education and Adherence Program Patient Advocacy Support Other: _____

If patient speaks a specific language other than English, please indicate here: _____



SECTION VI: Physician Information

Physician Name: _____ State License#: _____
NPI#: _____ Tax ID#: _____

Practice Details:

Practice Name: _____ Contact Person: _____
Address: _____ Contact Phone #: () -
City, State, ZIP: _____
Practice Phone #: () - Fax #: () -

Practice Shipping Address (if different from address listed above):

Address: _____
City, State, ZIP: _____
Shipping Contact Person: _____ Shipping Phone #: () -

To the best of my knowledge the information contained in this application is complete and accurate and this patient has no prescription insurance coverage either private or public (e.g. Medicaid), and meets the required income limits for participation in this Program. If I become aware of a change in income or insurance status that may effect Program participation of this patient, I will alert Program Sponsor. I understand that sanofi-aventis U.S. and the sanofi-aventis Foundation for Patient Assistance reserve the right to modify or terminate this program at any time without notice. I attest that I am not on the HHS/OIG list of Excluded Individuals. My signature certifies that prescription products received from this Program will be used for the above named patient only and will not be resold nor offered for sale, trade or barter and will not be returned for credit. I agree to participate in any recall of the product initiated by the manufacturer.

Physician or Licensed Prescriber Signature (required-no stamps): _____

**Please fax this completed Enrollment form, authorizations and other documents to the
MULTAQ Patient Support Program at
1-866-910-9024.**

MULTAQ Patient Support Program reserves the right to verify all information provided by healthcare professionals suspend participation where inadequate information is provided, and limit enrollment based on available sources.

MULTAQ Patient Support Program
PO Box 1074
San Bruno, CA 94066

Sanofi-aventis and/or its agents reserve the right in their sole discretion to modify or terminate any and all components of the MULTAQ Patient Support Program at any time.

For full prescribing information including boxed WARNINGS, please call 1-800-633-1610 or visit https://www.multaq.com/docs/consumer_pdf/pi.aspx



Patient Certification and Authorization to Disclose Information:

Patient Name: _____ states that the information and documents provided in connection with this application are complete and accurate and that I meet all eligibility criteria for participation in the program, including income limits. I agree to immediately inform a Program representative and my Doctor/Healthcare Provider if my income or insurance status changes during the course of my participation in this Program. I understand that application to the Program does not guarantee that assistance will be obtained, and (1) participation in this Program is subject to approval under Program guidelines, (2) approval is for a limited period and (3) periodic reapplication is required for continued participation. I understand that my information will be used by the Program Sponsor, sanofi-aventis, U.S., the sanofi-aventis Foundation for Patient Assistance and authorized third party agents involved in administration of this Program, (collectively "Program Sponsor"), for purposes of determining my participation in, and administering, the Program, which may include contacting me as well as my Doctor/Healthcare Provider, office/hospital staff, insurer (public/private) or others. I authorize and consent to release of identifiable information about me including medical, financial and insurance records and information as required for participation in the Program. My authorization includes release of information relating to treatment for substance abuse, psychiatric and/or medical conditions, and HIV test results or diagnosis, if required. I understand that identifiable information about me will be kept confidential and will not be further used or disclosed except to administer the Program, or as required by law. I understand that information I authorize to be disclosed may be re-disclosed and no longer protected by Federal privacy regulations. I agree that this authorization is voluntary and that I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment but I will not be able to participate in this Program. Unless revoked this authorization shall remain in effect throughout my participation in the Program, including subsequent re-application as required. I may withdraw this authorization at any time by written notification to my Doctor/Healthcare Provider; however withdrawal of authorization will terminate my participation in this Program and will not affect information already disclosed. I further authorize use of my Social Security number for identification and recordkeeping purposes. I hereby release, for myself and on behalf of my successors and assigns, Program Sponsor (collectively), their officers, directors, employees, and agents from any and all claims or liability arising from their conduct pursuant to this authorization or the use or disclosure of information relating to my Program participation as long as such use or disclosure is made in good faith and without malice and is consistent with this authorization. I understand that sanofi-aventis U.S. and the sanofi-aventis Foundation for Patient Assistance reserve the right at any time and without notice to modify or change eligibility criteria, or modify or discontinue this Program.

Signature of Patient or Guardian*

Date

*If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally)

Description of Authority

Sanofi-aventis and/or its agents reserve the right in their sole discretion to modify or terminate any and all components of the MULTAQ Patient Support Program at any time.