

Information about the Multaq® Patient Assistance Program and Reimbursement Hotline Services

- Once you qualify, you may be able to receive free medication for up to 12 months.
- If prescribed, up to a 90 day supply of medication will be sent to your healthcare practitioner. You will be able to refill your order every 3 months until the 12 months is complete.
- Call (888) 968-5827 and use the automated system to refill your medication.
- For patients with government or private prescription drug benefits the reimbursement hotline can assist in navigating the coverage process, including any barriers such as prior authorizations or step therapy restrictions.

MULTAQ® Patient Assistance Program Eligibility

- Patient must be a legal resident of the United States.
- Patient cannot have any government prescription coverage for MULTAQ® such as, Medicaid, Veteran’s Administration, or any state or local programs. Patient cannot have Medicare Part D prescription coverage. If the patient has Medicare Part D but is still having a problem affording their medication, please apply as sanofi-aventis U.S. may be able to help.
- Patient cannot have any private prescription drug coverage for MULTAQ®.
- Patient’s total yearly household income must be at or below the limits shown in the chart below:

<u>Household Size</u>	<u>Total Yearly Household Income</u>	<u>Total Monthly Household Income</u>
1	\$27,075	\$2,256
2	\$36,425	\$3,035
3	\$45,775	\$3,815
4	\$55,125	\$4,594
5	\$64,475	\$5,373
6+	\$73,825	\$6,152

Instructions for completing the application

1. Please indicate which services you are interested in by checking the box.
2. Fill out all of the information in the application and sign on the line that says “Patient’s signature”.
3. Take the application to your healthcare provider. Have your healthcare provider sign on the line that says “Original Signature of Licensed Healthcare Provider (No stamped signatures)”. Please be sure to provide your entire State License number or enclose a copy.
4. Have the healthcare provider fill out the Prescription Section area on the application or include an original prescription for MULTAQ® .
5. Attach a copy of your Federal Tax Return. If you do not file taxes please include another proof of yearly income such as pay stubs, a bank statement of deposit, or an attested letter describing your yearly income.
6. Finally, mail or fax the application, prescription (if not using Prescription Section on the application), and photocopy of Federal income tax return (or other proof of income) to fax number above, if you do not have access to a fax machine please mail the application to the address indicated above.

Please indicate the type of assistance you are requesting:

Reimbursement Services Only Patient Assistance Evaluation Both

PATIENT SECTION – The patient or his/her legal representative must complete this section

NAME:	(First)	(Middle)	(Last)
ADDRESS:			
CITY:	STATE:	ZIP CODE:	
DATE OF BIRTH:	PHONE NUMBER:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	
SOCIAL SECURITY NUMBER: _____ - _____ - _____ If you do not have a Social Security number, please provide another form of identification such as a Green Card number, Visa, etc.			
ARE YOU A LEGAL U.S. RESIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		If not, describe your residency status:	
DO YOU HAVE? Medicaid: YES <input type="checkbox"/> NO <input type="checkbox"/> VA Benefits: YES <input type="checkbox"/> NO <input type="checkbox"/>			
DO YOU HAVE PUBLIC OR PRIVATE PRESCRIPTION DRUG COVERAGE FOR MULTAQ®?			
Medicare Part D: YES <input type="checkbox"/> NO <input type="checkbox"/> Private: YES <input type="checkbox"/> NO <input type="checkbox"/> Other State or Local Programs: YES <input type="checkbox"/> NO <input type="checkbox"/>			
IF YOU ANSWERED YES TO THE ABOVE PLEASE PROVIDE YOUR PLAN INFORMATION:			
Plan Name: _____		Policy #: _____	
Plan Phone: _____		Effective Date: _____	
WHAT IS YOUR TOTAL ANNUAL HOUSEHOLD INCOME? (Including SSI, Pension income, etc.): \$			
HOW MANY PEOPLE ARE THERE IN YOUR HOUSEHOLD? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+ <input type="checkbox"/>			

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 re-application 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.

PATIENT'S SIGNATURE

Date

LICENSED PRACTITIONER SECTION – The licensed practitioner must complete this section

NAME:	OFFICE STREET ADDRESS: (No P.O. Box)		
<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> CNP <input type="checkbox"/> NP <input type="checkbox"/> OTHER _____			
CITY:	STATE	ZIP CODE:	
STATE LICENSE NUMBER:	OFFICE CONTACT PERSON:		
OFFICE PHONE #:	OFFICE FAX #:		

PRESCRIPTION INFORMATION

Product Name:	Strength:	Quantity Per Day:
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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.

LICENSED DR OR OTHER HCP (No stamps)

Date