



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

Phone: (800) 996-6626 P.O. Box 1074
Fax: (800) 996-6627 San Bruno, CA 94066
Provider Portal: www.pactplusonline.com

INSURANCE VERIFICATION SERVICES

- Please complete sections I, II, III, IV and VI of the PACT+ application. Please note that for an insurance verification only, we do not require the patient's income information.
- Please have the patient sign both Patient Authorization Forms.
- Please indicate the provider Tax ID, NPI, and State License# in Section VI.
- Submit the application and authorizations forms (pages 2–5) via the PACT+ Provider Portal (www.pactplusonline.com) or via Fax: 800-996-6627.

PATIENT ASSISTANCE PROGRAM SERVICES

- Please complete sections I, II, III, IV, V, and VI of the PACT+ application.
- Please have the patient sign both Patient Authorization Forms.
- Please be sure to indicate if we may contact your patient for our Alternative Services Program by checking off the appropriate box on Section V.
- Submit the application (pages 2 & 3), authorization forms (pages 4 & 5), and income documentation via the PACT+ Provider Portal (www.pactplusonline.com) or via Fax: 800-996-6627.

DRUG REPLACEMENT PROGRAM SERVICES

- Please complete sections I, II, III, IV, V, and VI of the PACT+ application. If you have already treated the patient, please indicate the dates of service in Section I.
- Please have the patient sign both Patient Authorization Forms.
- If your office chooses to seek drug replacement for past dates of service, a copy of the flow sheet(s) and drug inventory log (with patient name, product NDC/Lot # & dates of service) may be submitted at your convenience.
- Please indicate the provider Tax ID, NPI, and State License# in Section VI.
- Please be sure to indicate if we may contact your patient for our Alternative Services Program by checking off the appropriate box on Section V.
- Submit the application (pages 2 & 3), authorization forms (pages 4 & 5), flow sheet(s) and income documentation via the PACT+ Provider Portal (www.pactplusonline.com) or via Fax: 800-996-6627.

PROGRAM ELIGIBILITY

- An application must be submitted for each patient. Applications can be submitted via the PACT+ Provider Portal, fax, or via mail.
- 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 ≤500% of current Federal Poverty Level (FPL)

INCOME DOCUMENTATION

PACT+ 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 Statement, 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.

Please note: PACT+ reserves the right to contact the patient if clarification is needed.

ALTERNATIVE SERVICES

What checking "Yes" really means: If the "Yes" box is checked in Section V, a PACT+ Reimbursement Counselor will contact your patient to help find alternative services and resources provided by other organizations which may include, but are not limited to:

| | | | |
|--------------------------------|--|---|--------------------------|
| Referrals to Co-pay Assistance | Hospice | Clothing | Support Groups |
| Prescription Savings Program | Home Care Services | Utilities | Patient Advocacy Support |
| Nutritional Supplements | Medical Supplies/Devices | Transportation | Cancer Advocacy Groups |
| Other Drug Assistance Programs | Cosmetic Aids (wigs, scarves, makeup, etc.) | Groceries and Food Banks (Meals on Wheels, etc.) | Other |

PACT+ PROVIDER PORTAL

The PACT+ Provider Portal is a tool for your practice to enroll and manage patients in the PACT+ Program. It is tailored to fit your busy practice needs by providing quick and easy access to information at your fingertips.

This secure, web based Provider Portal is available to you free of charge and provides real-time access to patient case status information 24/7.

Log-in now to take advantage of the following online benefits:

| | | | |
|--|---------------------------------------|--|--|
| On-line Patient Enrollment Secure Messaging | PAP Shipment Tracking PAP Reorders | Access to Online Resources, Tools and Forms Patient Case Status Reporting | On-line Benefit Verification Summaries On-line Alerts and Reminders |
|--|---------------------------------------|--|--|

To register and receive secure access to the PACT+ Provider Portal, go to: www.pactplusonline.com



Please Note: In order to process this application, this form needs to be completed in its entirety including the physician's signature. Information supplied on this form will be held in strict confidence and will only be used for the administration of this program.

Which drug do you need assistance with?

Taxotere® (docetaxel) Injection Concentrate
Eloxatin® (oxaliplatin injection)
Oforta™ (fludarabine phosphate tablets)

Anzemet® (dolasetron mesylate) Tablets
Jevtana® (cabazitaxel)

Elitek® (rasburicase)
Nilandron® (nilutamide)

SECTION I: Treatment Information

Date(s) of Service: _____

Regimen: _____

ICD-9/Diagnosis (1st): _____ ICD-9/Diagnosis (2nd): _____

SECTION II: Prescribing Information

Drug: _____ Dosage: _____ mg/m² Frequency: _____ BSA: _____
Drug: _____ Dosage: _____ mg/m² Frequency: _____ BSA: _____
Drug: _____ Dosage: _____ mg/m² Frequency: _____ BSA: _____

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
- Annual limit reached
- Insurance without coverage
- Insurance with denied coverage
- Medicaid ineligible
- Lifetime limit reached
- Insured with drug coverage

SECTION III: 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: _____

I certify that to the best of my knowledge, information, and belief, the patient I am sponsoring for enrollment in the PACT+ 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 PACT+ 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 PACT+ Program.

SECTION IV: Insurance Information

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

Primary Insurance:

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

Secondary Insurance:

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



SECTION V: Alternative Services

May PACT+ contact the patient directly for referrals to alternative services/resources? Y N

Please mark which services/resources your patient may be interested in:

- | | | | |
|--------------------------------|--|---|--------------------------|
| Referrals to Co-pay Assistance | Hospice | Clothing | Support Groups |
| Prescription Savings Program | Home Care Services | Utilities | Patient Advocacy Support |
| Other Drug Assistance Programs | Medical Supplies/Devices | Transportation | Cancer Advocacy Groups |
| Nutritional Supplements | Cosmetic Aids (wigs, scarves, makeup, etc.) | Groceries and Food Banks (Meals on Wheels, etc.) | Other: _____ |

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

SECTION VI: Physician Information

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

Facility Details:

Facility Type: Community Practice Hospital Outpatient Infusion Center Hospital Inpatient
 Facility Name: _____ Contact Person: _____
 Address: _____ Contact Phone Number: () - _____
 City, State, ZIP: _____
 Phone #: () - _____ Fax #: () - _____

Shipping Details:

Shipping Address (if different from address listed above): _____
 City, State, ZIP: _____
 Shipping Contact Person: _____ Shipping Phone Number: () - _____

I certify that all other avenues of financial assistance 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.
 I attest that I am not on the HHS/OIG list of Excluded Individuals. My signature certifies that prescription products received from the PACT+ 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 product initiated by the manufacturer.

Physician Signature (required-no stamps): _____

Please submit the application electronically via the PACT+ Provider Portal at
www.pactplusonline.com
or fax this completed form, authorizations and other documents to the PACT+® Program at
1-800-996-6627.

PACT+ 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.
PACT+ 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 PACT+ program at any time.

For full prescribing information including boxed WARNINGS, please call 1-800-633-1610 or visit
www.oncology.sanofi-aventis.us



Patient Certification and Authorization to Disclose Information:

I attest that the information supplied by me herein is complete and accurate. I understand that this information is for the sole use of sanofi-aventis, its representatives, and/or agents selected in order to assess my eligibility for participation in the Patient Assistance Program (collectively, the "Program") and will not be disclosed to any third party, except as required by law. I authorize my physician to release insurance and basic information about my health to sanofi-aventis, sponsor of the Program ("Sponsor"), and to its authorized agent(s), including administrator of the Program ("Participant"), currently the Lash Group. This information will be used to contact the patient's insurer or health plan to determine product coverage and reimbursement policies, and to conduct inquiries and follow-up on specific product claims submitted to the insurer or plan on behalf of the patient. By signing below, I also authorize the Participant to make such contacts with the insurer or health plan, and to conduct such claims inquiries and follow-up, as necessary. As a covered entity under HIPAA, the Participant will treat all patient information confidentially, and will use such information solely for the purposes of assisting patients and administering the Program.

I understand that application to the Program does not guarantee that assistance will be obtained. I understand that eligibility for the Program is subject to approval under the Program guidelines, and that sanofi-aventis, reserves the right to change or terminate this Program without prior notice. I understand that this assistance will be provided for a single course of treatment and that I may be asked to reapply at designated intervals (e.g. every 6 months). I certify that written documentation (for example, copies of tax returns) provided to verify the financial information I have provided is complete and accurate, and that this information and the supporting documents I have provided accurately represent my financial situation. I further understand and agree that the documents supporting this information will be retained by my doctor or health-care provider, and are subject to audit by sanofi-aventis and/or its designated agents, and agree to cooperate in the event my records are selected for audit. I understand that this documentation will be kept confidential under the same terms as the information provided in this application. I understand that my failure to provide documentation as requested will disqualify me from the Program. I certify that payment for the product specified on this application would pose a financial hardship. I agree to immediately inform my physicians and/or a Program representative if my income or insurance status changes. I agree to abide by this certification throughout my participation in the Program and to notify a Program representative if any aspect of my certification is no longer applicable.

I hereby consent to the release of insurance and clinical information as described above. I also hereby release, on my behalf and on behalf of my successors and assigns, Sponsor and Participant, their officers, directors, employees, and agents from any and all claims or liability arising from their conduct pursuant to this consent, or the use or disclosure of information relating to Sponsor's or Participant's provision of services to me, as long as such use of disclosure is made in good faith and without malice, and conforms to the terms of this consent. I understand that my consent is subject to revocation at any time, except to the extent that action has been taken in reliance on this consent. Unless revoked earlier, this consent shall remain in effect during the term of a course of treatment and until such time as a new application becomes or would become effective.

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 PACT+ Program at any time.



**AUTHORIZATION TO DISCLOSE INFORMATION ABOUT ME
IN THE PATIENT ASSISTANCE PROGRAM**

Sanofi-aventis offers a Patient Assistance Program to help qualified patients receive their medicines. I understand that sanofi-aventis needs certain information about me to see if I qualify under the Program for assistance in receiving its product. I request and authorize my doctor, _____ (“Doctor”), and my health insurance company, _____ (“Insurer”), to give sanofi-aventis, including representatives or agents who work on behalf of sanofi-aventis in this Program, information about my health-care treatment and insurance coverage. The type of information that may be given to sanofi-aventis includes information that identifies me, such as my name, address, social security number, financial information, diagnoses, prior treatments, and information about my health plan benefits.

I know that I need to sign this authorization to take part in this Patient Assistance Program. If I do not sign this authorization, my decision will not affect my ability to obtain treatment or to seek payment for treatment. I also know that I can cancel this authorization at any time by writing to my Doctor or sanofi-aventis. Doctor’s mailing address is: _____.
If I cancel this authorization, then Doctor and Insurer will stop providing sanofi-aventis with information about me. However, I cannot cancel actions that they have already taken by relying on my authorization.

I understand that once Doctor and Insurer give sanofi-aventis information about me based on this authorization, federal privacy laws may not prevent sanofi-aventis from further disclosing my information. However, sanofi-aventis has agreed that it will only use information about me to determine my eligibility for this program, to administer the program, and to account for my withdrawal if I decide to stop participating in this program. I also understand that signing this authorization does not guarantee that I will be able to get the product from sanofi-aventis at reduced or at no cost. This authorization is good for as long as I participate in the sanofi-aventis Patient Assistance Program.

A copy of this signed form will be returned to me for my records.

Patient:

Signature of Patient or Guardian*

Date

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

Name (please print)

Description of Authority

NOTE: Sanofi-aventis reserves the right to limit or modify, in whole or in part, the Patient Assistance Program (PAP), or to terminate the program at any time, without further notification. In addition, no patient will be accepted into the program without the provider’s and patient’s (or guardian’s) original signature on this form.