

Sanofi Pasteur Inc. Patient Assistance Program

Phone: (866) 801-5655

Fax: (866) 734-7371

INSTRUCTIONS:

- BOTH THE PATIENT AND HEALTH-CARE PROVIDER WILL BE RESPONSIBLE FOR COMPLETING THEIR APPROPRIATE SECTIONS OF THE APPLICATION.
- PATIENT AND HEALTH-CARE PROVIDER MUST SIGN THE APPLICATION FOR EACH REQUEST.
- HEALTH-CARE PROVIDER WILL BE ADVISED IN WRITING OF ANY DENIED REQUESTS.
- INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE HEALTH-CARE PROVIDER FOR COMPLETION.
- HEALTH-CARE PROVIDER MUST PROVIDE OFFICE HOURS AND DAYS FOR DELIVERY.

PROGRAM ELIGIBILITY:

- PATIENT MUST BE A RESIDENT OF THE UNITED STATES.
- PATIENT MUST BE 19 YEARS OF AGE OR OLDER (EXCEPT REQUESTS FOR IMOVAX RABIES AND IMOGAM RABIES HT).
- PATIENT MUST BE UNDER THE CARE OF A HEALTH-CARE PROVIDER DULY LICENSED AND AUTHORIZED TO PRESCRIBE, DISPENSE, AND ADMINISTER REQUESTED VACCINE.
- PATIENT CANNOT BE ENROLLED IN OR QUALIFY TO BE ENROLLED IN ANY FORM OF MEDICATION REIMBURSEMENT PROGRAM, INCLUDING CITY, COUNTY, STATE OR FEDERAL FUNDED PROGRAMS OR ANY PRIVATE INSURANCE PLANS.
- PATIENT MUST MEET THE FINANCIAL CRITERIA OF LESS THAN OR EQUAL TO 200% OF THE FEDERAL POVERTY LEVEL. PLEASE SEE CHART BELOW:

Household size	200% Federal Poverty Level:
1	\$20,800
2	\$28,000
3	\$35,200
4	\$42,400
5	\$49,600
6	\$56,800

VACCINE INFORMATION:

**AVAILABLE:
IMOGAM[®] RABIES HT • IMOVAX[®] RABIES •
MENOMUNE[®] • THERACYS[®] • ADACEL[®] • DECAVAC[®]
MENACTRA[®]**

Please Note:

REQUESTS FOR **MENACTRA[®]**, **DECAVAC[®]** AND **ADACEL[®]** VACCINES ARE AS FOLLOWS:

- EACH VACCINE COMES IN MULTI-DOSE PACKAGE.
- HEALTH-CARE PROVIDER MUST PRESTOCK DIRECT PURCHASE FROM SANOFI PASTEUR INC.
- HEALTH-CARE PROVIDER MUST ALSO PROVIDE LOT # (and INVOICE NUMBER, IF AVAILABLE) OF CURRENT STOCK TO RECEIVE PER-DOSE CREDIT.
- INSURANCE VERIFICATION WILL BE PERFORMED ON PATIENTS BETWEEN THE AGES OF 19 – 23 REQUESTING MENACTRA VACCINE.

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Licensed Health-care Provider Information

Name _____ Title _____

Practice Name _____

Shipping Address _____ Sanofi Pasteur Inc. Customer Number _____

City _____ State _____ Zip _____

Office Hours and Days _____ Delivery hours _____

() _____ () _____

Phone Number _____ Fax Number _____

Prescriber State License # with expiration date _____

() _____

Office Contact Name _____ Contact Phone Number _____

VACCINE Information

IMOVAX® Rabies Vaccine - # of Doses _____ **TheraCys®** BCG Live - # of Doses _____

Imogam® Rabies HT Vaccine - Patient's Weight _____ **Menomune®**A/C/Y/W-135 - # of Doses _____

Credit only (one dose per patient):

Menactra® - Lot # _____ **Decavac®** - Lot # _____ **Adacel®** - Lot # _____

Sanofi Pasteur Inc. Invoice # _____

ADACEL® / DECAVAC® Requests:

Please check the applicable box(es) below to identify the purpose for administration:

Patient has contact with infants 12 months of age or younger.

Patient lives in a community with a pertussis outbreak.

Routine booster

Patient Information

Name of Patient _____

Address _____ City _____ State _____ Zip _____
() _____

Phone Number _____

Date of Birth _____ SS# _____

1. Is the patient a resident of U.S.? YES NO

2. What is the total **ANNUAL** household income, including social security and pension benefits? _____

3. Household size _____

5. Does the patient have or qualify for prescription coverage in any government program? YES NO

6. Does the patient have or qualify for prescription coverage in any private program? YES NO

7. If yes to #5 or #6, provide the following insurance information:

Name _____ Policy # _____ Group # _____
() _____

Phone Number _____

Address _____ City _____ State _____ Zip _____

Subscriber's Name _____ Date of Birth _____ Subscriber's SS# _____

Patient Statement

I hereby authorize any insurer, either public or private, employer, hospital, physician or any other healthcare provider to disclose to Sanofi Pasteur Inc. and its agents all financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in the Sanofi Pasteur Inc. Patient Access Program. I also authorize Sanofi Pasteur Inc. and its agents to disclose all such records and information to the persons or entities listed above for the purpose of my participation in the Program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I verify that the information provided in this application is complete and accurate. I certify that I am ineligible for any type of government or private prescription coverage for this treatment. I understand that Sanofi Pasteur Inc. reserves the right at any time and without notice to modify the application or modify or discontinue this program and the related eligibility criteria. I authorize Sanofi Pasteur Inc. to use my Social Security number for identification purposes and record keeping only. I have read, understand and agree to all of the above.

Patient's Signature _____ Date _____

Licensed Health-care Provider Statement

I represent that the information contained in this application is complete and accurate to the best of my knowledge. I certify that the use of the indicated medication is medically necessary and I will be evaluating the patient's treatment. To the best of my knowledge, this patient has no prescription insurance coverage, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed medication. I understand that Sanofi Pasteur Inc. reserves the right to modify or terminate this program at any time. My signature certifies that these goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that Sanofi Pasteur Inc. reserves the right to recall the vaccine when necessary.

Licensed Health-care Provider's Signature _____ Date _____