



Sculptra™ Patient Access Program
sanofi-aventis
Patient Assistance Foundation Program
P.O. Box 430 Somerville, NJ 08876
(866) 310-7551P / (866) 364-2016F

Information about the Sculptra™ Patient Access Program

- Sculptra is subject to specific criteria for diagnosis and dispensing, acceptance into the program may include a share of the cost. Once you qualify, for free or shared cost of Sculptra™ your enrollment cycle will be 18 months, with a maximum of 8 kits allowed within this cycle.
- Both the patient and practitioner will be advised in writing of any denied requests.
- Incomplete applications will be returned for completion.
- Please allow 2-3 weeks for processing and delivery to the practitioner's office for approved patients.
- **Please note that assistance obtaining Sculptra™ through the Sculptra™ Patient Access Program does not include the practitioner fees.**

Instructions for completing the application

1. Fill out all of the information in the application and sign on the line that says "Patient's signature".
2. Take the application to your physician. Have your physician sign on the line that says "Original Signature of Licensed Practitioner (No stamped signatures)".
3. Attach a copy of your Federal Tax Return. If you do not file taxes please include another proof of yearly income such as paystubs, a bank statement of deposit, or an attested letter describing your yearly income.
4. Have the physician fill out the Prescription Section below or include an original prescription.
5. 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 the address or fax number above.

Program Eligibility

- Patient must be a legal resident of the United States.
- Patient cannot have or qualify for state or federal reimbursement for Sculptra™.
- Patient cannot have private insurance reimbursement for Sculptra™.
- Patient claiming to have prescription coverage but no Sculptra™ coverage will be required to provide insurance information.
- Practitioner must acknowledge receipt of materials regarding product administration.
 - TO OBTAIN MATERIALS ON PRODUCT ADMINISTRATION, PLEASE CALL 888-728-5782 (888-SCULPTRA).
- Practitioner must confirm that Sculptra™ will be used consistent with the FDA approved indication.
- Patient's income eligibility for full or partial assistance extends up to \$80,000 annual household income as reported on the patient's Federal Income Tax return.
- The amount of patient contribution, if any, will depend on income and household size.



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

NAME:	(First)	(Middle)	(Last)
ADDRESS:			
CITY:	STATE:	ZIP CODE	PHONE NUMBER
DATE OF BIRTH:	GENDER: M <input type="checkbox"/> F <input type="checkbox"/>	SSN# <i>If you do not have a SSN#, please provide another form of I.D. such as a Green Card number or Visa.</i>	
ARE YOU A LEGAL U.S. RESIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If not, please describe your residency status:</i>		WHAT IS YOUR TOTAL ANNUAL HOUSEHOLD INCOME? (Including Social Security, 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"/>			
DOES THE PATIENT HAVE OR QUALIFY FOR GOVERNMENT PRESCRIPTION COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>(Medicaid, Medicare D, Veteran's Benefits or Other State or Government Programs)</i>			
DOES THE PATIENT HAVE OR QUALIFY FOR PRIVATE PRESCRIPTION COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>			
DOES THE PATIENT HAVE OR QUALIFY FOR SCULPTRA PRESCRIPTION COVERAGE IN ANY PRIVATE OR GOVERNMENT PROGRAM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
IF YES TO ANY OF THE ABOVE INSURANCE QUESTIONS PLEASE PROVIDE DETAILED INSURANCE INFORMATION			
Name:	Policy#	Group#	Phone #
Address	City	State	Zip

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 Dr/HCP 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 Dr/HCP, 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 Dr/HCP; 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:	PROFESSIONAL DESIGNATION: (MD, DO, ETC.):		
OFFICE ADDRESS: (No P.O. Box)			
CITY:	STATE:	ZIP CODE:	
STATE LICENSE NUMBER:	SCULPTRA FACILITY NUMBER:		
OFFICE CONTACT PERSON:	OFFICE PHONE #:	OFFICE FAX #:	

PRESCRIPTION INFORMATION

Sculptra™ Number of Kits (2 vials per kit) for above named Patient:	<input type="checkbox"/> 1 Kit	<input type="checkbox"/> 2 Kits
The use of the product for this patient is consistent with the following FDA-approved indication for Sculptra™: <i>Sculptra™ is intended for restoration and/or correction of the signs of facial fat loss (lipoatrophy) in people with human immunodeficiency virus.</i> YES <input type="checkbox"/> NO <input type="checkbox"/>		

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 doctor or other licensed healthcare provider (No stamps)

Date