

Dear Healthcare Professional:

Thank you for inquiring about the Aventis Oncology PACT+<sup>SM</sup> Program. Attached is a qualification form for your Anzemet<sup>®</sup> (dolasetron mesylate) injection/tablets patient with CINV.

**PLEASE TAKE A MOMENT TO READ THESE IMPORTANT INSTRUCTIONS.**

1. Complete and sign the original qualification form. You will note the bottom half of the form acts as a prescription and must be completed carefully.
2. Please ensure you have obtained the necessary consent from your patient permitting you to divulge this information.
3. Fax the completed application to PACT+ at 1-800-996-6627 and retain a copy for your records.

PACT+ will review the form and confirm your patient's eligibility within 48 hours of receipt. Eligible patients will be granted up to a 3-month course of Anzemet<sup>®</sup> at no cost. Upon initial eligibility, a 1-month supply of Anzemet<sup>®</sup> therapy will be shipped directly to the physician.

Aventis Pharmaceuticals reserves the right to verify all information provided, suspend participation where inadequate information is provided, and limit or suspend enrollment based on available resources. If you have any questions, or would like to enroll other patients, please do not hesitate to contact us at 1-800-996-6626, Monday through Friday, 8:30 AM to 6:00 PM ET.

Sincerely,

The Aventis Oncology PACT+ Program

**PACT+<sup>SM</sup> Contact Information**

Phone: 1-800-996-ONCO (6626)

Fax: 1-800-996-6627

E-mail: [ePACT@access2health.com](mailto:ePACT@access2health.com)

Hours of operation: M–F 8:30 AM–6:00 PM ET

[www.AventisOncology.com](http://www.AventisOncology.com)

Anzemet<sup>®</sup> CINV Patient Assistance Program

100 Grandview Road, Suite 210

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ONCOLOGY

*Aventis Pharmaceuticals*  
Bridgewater, NJ 08807

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**The Aventis Oncology PACT+<sup>SM</sup> Program for  
Anzemet<sup>®</sup> (dolasetron mesylate) injection/tablets  
CINV Patient Assistance Program Qualification Form  
For Information: 800-996-ONCO (6626)  
E-mail: ePACT@access2health.com**



**Instructions:** Completion of this form in its entirety, including the physician's signature, is required to process this application. Information supplied on this form will be held in strict confidence and will only be used for the administration of this program.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_ Diagnoses: \_\_\_\_\_  
 Patient Phone #: \_\_\_\_\_  
 Gender: \_\_\_\_\_ ICD-9s: \_\_\_\_\_

**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.**

- |  |   |
|--|---|
| <input type="checkbox"/> Uninsured<br><input type="checkbox"/> Insurance with drug coverage<br><input type="checkbox"/> Annual limit reached<br><input type="checkbox"/> Lifetime limit reached<br><input type="checkbox"/> Insurance without coverage for Anzemet <sup>®</sup><br><input type="checkbox"/> Insurance with denied coverage for Anzemet <sup>®</sup><br>(A copy of the denial must be included with the application.)<br><input type="checkbox"/> Medicaid ineligible | Total # of People in the Household: _____<br>Total Annual Income: _____<br>Insurer: _____<br>Policy ID #: _____<br>Group: _____ |
|--|---|

### PHYSICIAN INFORMATION

Physician Name: \_\_\_\_\_  
 Physician DEA #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_  
 Office Contact Name: \_\_\_\_\_  
 Office Contact Phone #: \_\_\_\_\_

### PRESCRIBING INFORMATION

IV Dosage: \_\_\_\_\_ mg q \_\_\_\_\_ × \_\_\_\_\_  
 Oral Dosage: \_\_\_\_\_ mg q \_\_\_\_\_ × \_\_\_\_\_  
 Sig: \_\_\_\_\_

### SHIPPING INFORMATION

Attention: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_

I certify that all other avenues of financial assistance for acquiring Anzemet<sup>®</sup> 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.

Physician signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

**Please fax this completed form to the Aventis Oncology PACT+ Program at 800-996-6627.**

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