PACT PLUS[SM] *Providing Access to Cancer Therapy*

Dear Healthcare Professional:

Thank you for inquiring about the Aventis Oncology PACT+[SM] Program. Attached is a qualification form for your Anzemet® (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® at no cost. Upon initial eligibility, a 1-month supply of Anzemet® 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+[SM] Contact Information**

Phone: 1-800-996-ONCO (6626)
Fax: 1-800-996-6627
E-mail: ePACT@access2health.com
Hours of operation: M–F 8:30 AM–6:00 PM ET
www.AventisOncology.com
Anzemet® CINV Patient Assistance Program
100 Grandview Road, Suite 210
Braintree, MA 02184

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# The Aventis Oncology PACT+SM Program for Anzemet® (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: ____________________

Address: ____________________

City, State, ZIP: ____________________

Patient Phone #: ____________________

Gender: ____________________

Date of Birth: ____________________ Age: ______

Social Security #: ____________________

Diagnoses: ____________________

____________________

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.**

- ❑ Uninsured
- ❑ Insurance with drug coverage
  - ❑ Annual limit reached
  - ❑ Lifetime limit reached
- ❑ Insurance without coverage for Anzemet®
- ❑ Insurance with denied coverage for Anzemet® (A copy of the denial must be included with the application.)
- ❑ Medicaid ineligible

Total # of People in the Household: ____________________

Total Annual Income: ____________________

Insurer: ____________________

Policy ID #: ____________________

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® 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.**

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 resources.

Anzemet® CINV Patient Assistance Program, 100 Grandview Road, Suite 210, Braintree, MA 02184