Multaq® (dronedarone) STATEMENT OF MEDICAL NECESSITY

Patient Information

Last Name:_____ First Name: _____ Date of Birth: _____

Street Address:_____ City: _____ State:_____ Zip Code:_____

Preferred Contact Number:_____ ☐ Home ☐ Cell ☐ Work_____

Medical Insurance Name (required for confirmation of payer policy):_____ Policy Number:_____

Prescription Insurance Name (required for PA submission): _____ Policy Number:_____

Diagnosis and Clinical Information

Diagnosis Code and/or Description:	
Is the patient currently on rate control therapy?	☐ Yes ☐ No
What AAD therapy has the patient taken in the last 6 months?	
Does the patient have a history of liver or lung toxicity?	☐ Yes ☐ No
Additional Information:	
Does the patient have a diagnosis of structural heart disease?	☐ Yes ☐ No
Additional Rationale:	

Treatment Plan and Authorization

Medication: Multaq® (dronedarone) 400 mg			
Directions for Use:			
Prescriber Last Name:	Prescriber First Name:	Practice Name:	
Address:	City:	State:	Zip:
Tax ID#:	State License#:	NPI#:	
Practice Contact:	Contact Phone:	Contact Fax:	
Service Requested (check one or both):	☐ **Prior Authorization**	☐ **Medical Exception (if appeal required)**	

I certify that the information provided is current, complete, and accurate to the best of my knowledge and certify that **Multaq® (dronedarone)** is medically necessary for this patient. I certify that I have obtained from my patient all required written authorization for the release of my patient's personal identification, medical and insurance information to Sanofi US and their agents and representatives. I authorize Sanofi Patient Connection, as a program that maintains technical and administrative safeguards, policies, and procedures that meet HIPAA requirements, to provide all of the included information to the patient's insurance company for the specific purposes of benefit verification, prior authorization determination, or medical exception purposes.

Prescriber Signature:	**Printed Name:**	**Date:**

Please fax completed form to: 866.682.9280
Call 888.847.4877 with any questions

Please note: *This letter is intended as an example for your consideration and may not include all the information necessary to support your prior authorization request. Requirements will vary based on the health plan guidelines and patient benefit design. Please note the requesting provider is entirely responsible for ensuring the accuracy, adequacy, and supportability of all information provided.*