

Request for 340B Retroactive Refunds

for Angiomax® and Cleviprex®

Covered Entity Name: _____

Covered Entity Address: _____

340B ID number: _____

The attached documentation is provided in support of a request for a refund between the purchase price and eligible 340B price of Angiomax® and/or Cleviprex®, purchased for individuals meeting the definition of “a patient” under the 340B statute and applicable program guidance. I certify that all information and statements made in this submission are true, complete, and current to the best of my knowledge and belief and are made in good faith. I understand that information contained in this submission may be subject to review by The Medicines Company for compliance with 340B program guidelines and that The Medicines Company has a right to audit our request for compliance with these guidelines in accord with the 340B statute and 340B program audit guidance. We understand that approved refund requests will be conditioned upon our releasing The Medicines Company and its predecessors and current and former parents, affiliates, divisions, subsidiaries, successors, transferees, heirs, and assigns, and their current and former directors, officers and employees, individually and collectively, from liability for past pricing related to the sales upon which the rebate is made.

The undersigned, certifies that he/she is the duly qualified and acting [title] of [hospital name] and, in such capacity, has the authority to execute and deliver this Certification on behalf of [hospital name].

Signature: _____

Printed Name: _____

Title: _____

Contact Information (phone, email): _____

Date: _____