Kineret® (anakinra) ON TRACK™

Instructions for Healthcare Providers

To prescribe Kineret, please follow these steps:

1. **Have your patient read the Patient Consent Information and sign on the indicated areas of the Referral Form**

   Give your patient a copy of the Patient Consent Information pages.

2. **Complete the rest of the Referral Form**

   Please fill out all required fields of the Referral Form. Incomplete fields may delay the start of treatment. Attach a front and back copy of the patient's insurance and drug/prescription benefit cards (if available).

3. **Fax Referral Form to 866-549-7219**

Your patient will be contacted by Kineret On TRACK to arrange for delivery of Kineret.

If you have any questions, please call Kineret On TRACK at 866-547-0644 or want to learn more about Kineret, visit Kineretrx.com.

Instructions for Patients

To get started on Kineret, please follow these steps:

1. **Read the Patient Consent Information and sign in Section 4 of the Referral Form**
2. **Your healthcare provider will fill out the rest of the form**
3. **You will receive a call from Kineret On TRACK to discuss the next steps in getting your Kineret prescription filled**

   These calls may come up from an 866 number, "unknown number" or "no caller ID."

4. **Kineret On TRACK will work with you to have Kineret delivered directly to you**

   If you have any questions, please call Kineret On TRACK at 866-547-0644 or want to learn more about Kineret, visit Kineretrx.com.

PATIENT CONSENT INFORMATION

Please read the following and sign in Section 4 of the Referral Form

By signing this Authorization, I authorize my healthcare providers, insurance companies, pharmacies or caregiver or other personal representative, to disclose in electronic or other forms of my personal and protected health information, such as my name, address, medical records, prescription and insurance information, to or by the following: Sobi, Inc. and its subsidiaries and affiliates, contractors, employees, agents and successors (collectively, "Kineret On TRACK").

Kineret On TRACK will provide support services including insurance and reimbursement assistance. Such authorization allows for support in the receipt of treatment; claims settlement; submission of claims to health insurers for payment; communication of information to my physician, other health care providers, and insurance carriers; reimbursement services; eligibility for any financial assistance; and administration of Kineret On TRACK. I also authorize and understand that Kineret On TRACK and other health care providers involved in my care may use and disclose my protected health information for quality assurance purposes, including but not limited to quality assurance reviews. Kineret On TRACK is authorized to contact me by mail, e-mail, text, telephone, and/or any alternative communication method that I request for the purposes as described herein.

I understand that third parties may receive payment from Sobi or those acting on behalf of Sobi in exchange for disclosing protected health information to Kineret On TRACK and/or for providing me with support services for the purposes described herein.

I understand that I am not required to sign this Authorization as a condition to receiving treatment with Sobi's products or payment for health care; enrolling in a health plan; or establishing eligibility for benefits. I will be given a copy of this Authorization after I sign it.

I understand that this authorization shall remain in effect until it expires, unless I revoke it sooner. I may revoke this Authorization at any time by contacting Kineret On TRACK by phone at 866-547-0644 or in writing at AllCare Plus Pharmacy, 50 Bearfoot Rd, Northborough, MA 01532, Attn: Kineret On TRACK.

I understand that the revocation will be effective upon actual receipt of my letter by Kineret On TRACK at the above address. If I do withdraw the authorization, it can no longer be relied upon to make uses and disclosures of my protected health information, but that will not invalidate uses and disclosures already made in reliance upon this authorization.

I understand that the protected health information released based on this Authorization may be subject to redisclosure by Kineret On TRACK, and therefore may no longer be protected by certain federal privacy regulations, but Kineret On TRACK plans to use and disclose the information only as described within this authorization.

This Authorization expires five (5) years (or such lesser time as state law may require) from the date this Authorization is signed.

Patient Referral Form PHONE: 866-547-0644

Fax the referral form to Kineret ON TRACK at 866-549-7219.

Please attach front and back copy of the patient's insurance and drug/prescription benefit cards (if available). Complete all ***REQUIRED** fields in this form.

Kineret® (anakinra) ON TRACK™

1 Patient Information

*Full Name:	*Gender: M ❑ F ❑	*DOB:
Parent/Guardian Name:	Parent/Guardian Phone:	
*Address:	City/State:	*ZIP:
*Primary Phone:	Cell Phone:	
*Email Address:	*U.S. Citizen: Y ❑ N ❑	

2 Prescription Insurance Information

Prescription Insurance Name:	*Patient Uninsured: Y ❑ N ❑	
*Group #:	*ID#:	*BIN:
*Policyholder Date of Birth:	*Policyholder Name:	
*Relationship to Patient:		

3 Medical Insurance Information

*Medical Insurance Name:	*Patient Uninsured: Y ❑ N ❑	
*Group #:	*Policy #:	
*Policyholder Date of Birth:	*Policyholder Name:	
*Relationship to Patient:		

4 Patient Consent

I have read and understand the Patient Consent Information.

*Signature of patient or patient representative _____ ❑ Patient ❑ Patient Representative

*If signed by patient representative, please explain authority to act on behalf of the patient:_____

5 Prescriber Information

*Prescriber Name:		PA # on file (if applicable):		
*Phone:		*Fax:		
*Primary Address:		*City:	*State:	*ZIP:
Specialty:	*Tax ID#:	*NPI #:	*DEA #:	

6 Office Contact Information

Office Contact Name:		Preferred Method of Communication:
Phone:	Fax:	Email:

7 Kineret Prescription

Prescribers in all states must follow applicable law for a valid prescription. For prescribers in states with official prescription form requirements, such as New York, please submit a prescription along with this form in compliance with your state statutes and regulations.

Patient Name:	Patient DOB:
Patient Address:	

❑ I would like my patient and/or his/her caregiver to receive training on the self-administration of KINERET®

Previous therapy:_____

KINERET® 100 mg/0.67mL Solution ❑ 28 (twenty-eight) syringes ❑ 7 (seven) syringes ❑ Other: _____

Directions: Inject _____ mg subcutaneously every _____ Refills: _____

_____ _____

Doctor/Prescriber Signature – Dispense as Written
Stamped signatures cannot be accepted

Doctor/Prescriber Signature – Substitution Permissible
Stamped signatures cannot be accepted

8 Prescriber Consent

*Prescriber Name (Please Print):	*Prescriber Signature (Required):	Date:

By signing above, I acknowledge that I have obtained the patient's authorization to release the information contained in this form and such other information as may be required by Sobi, Inc. and its employees, agents or contractors in connection with Kineret On TRACK to assist the patient in obtaining coverage for Kineret and/or to assist the patient in initiating or continuing Kineret therapy. I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge.

I have prescribed Kineret based on my judgment of medical necessity and I will be supervising the patient's treatment. I authorize the forwarding of this prescription to the dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient may seek reimbursement for any free product received under any program.