KINERET® Patient Assistance Application

Kineret® (anakinra) ON TRACK™

Application Instructions

IMPORTANT – PLEASE COMPLETE THIS APPLICATION AND FOLLOW THE INSTRUCTIONS BELOW:

1. **Attach Proof of Income. (Examples: latest federal or state tax return, latest W-2 statement, SSDI/SSI award letter, last 3 months of bank statements showing income deposits, last 2 pay stubs.)**
   - **If patient does not have proof of income, patient may complete a notarized income statement or attestation statement form furnished on request by contacting Kineret On TRACK, 1-866-547-0644.**
2. **PLEASE SUBMIT COPY OF PATIENT'S CURRENT PRESCRIPTION INSURANCE CARD WITH THIS FORM.**
3. **Please fax the Patient Assistance Application to Kineret ON TRACK at 866-549-7219.**

1 Patient Information (*Required Information)

*First Name:	MI:	*Last Name:	*Sex: M ☐ F ☐
Email:	SSN:	*DOB:	
*Address:	City:	*State:	
*Number of dependents in household (including self):	*US Citizen or Resident? Y ☐ N ☐		
Are you a Veteran of the US Armed Forces? Y ☐ N ☐			
Have you received disability payments from Social Security for more than 24 months? Y ☐ N ☐			
Allergies:	Other Medications:		

2 Insurance Information

Private Prescription Drug Coverage? Y ☐ N ☐	Medicare Part A? Y ☐ N ☐
Elderly State Drug Assistance? Y ☐ N ☐	Medicare Part B? Y ☐ N ☐
AIDS Drug Assistance Program? Y ☐ N ☐	Medicare Part D? Y ☐ N ☐
	Medicaid? Y ☐ N ☐
*Have you received a denial letter for a Low Income Subsidy application? Y ☐ N ☐ *If yes, please attach a copy of all appeal/denial letters from your insurance company with the application	

3 Prescriber Information (*Required)

*Physician Name:	Specialty:	
*Hospital/Clinic Name:		
*City:	*State:	*Phone:

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4 Prescription Information: 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:

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

Directions: Inject _____ **mg subcutaneously every** _____ **Refills:** _____ ☐ **Dispense as written**

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

5 Patient Certification and Authorization to Disclose Information

By signing below, I allow Sobi, Inc. and other entities involved with PAP/Reimbursement Program and their employees, distributors or agents, to use and share my health information to administer the medication-access program and any related patient-assistance programs. I also allow my health plans, other payers, pharmacies, and other healthcare providers to give my health information to Sobi, Inc. as needed to help find ways to pay for Sobi's products, or for treatment or healthcare operations purposes. I agree that my health information may be given to insurance companies, the Food and Drug Administration, or other government agencies (to comply with state and federal regulation or coverage eligibility requirements), charities, or other parties as necessary to participate in the medication-access program and run the program. I know that this program may be changed or stopped by Sobi at any time. I know that completing this form does not ensure that I will receive financial assistance or therapy. I understand that Sobi, Inc. does not promise to find ways to pay for my prescription, and I know that I am responsible for the costs of my care. I also certify that the information I have set forth in this application is true, correct, and complete.

*Signature of Patient or Legal Guardian (Required to process application)

⇨	**Date:**

6 Patient Attestation and Signature

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I also promise to notify Sobi, Inc., should my circumstances change such that the information provided is no longer current (e.g. change in insurance coverage or employment status).

I hereby authorize Sobi, Inc., to obtain and disclose information from physicians and insurance companies and other information as necessary to verify the information provided in this application, although Sobi, Inc., is not obligated to verify any of the information contained in Section 1 above or confirm other medications that I am taking.

*Signature of Patient or Legal Guardian (Required to process application)

⇨	**Date:**

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