Kineret ON TRACK

PRESCRIPTION AND ENROLLMENT FORM

- Call **Kineret ON TRACK** at **1-866-547-0644** Monday through Friday 8:30 AM to 7 PM ET, or visit **Kineretrx.com**
- **Healthcare providers**, please complete this form and fax it to **Kineret ON TRACK** at **1-844-688-7624**, or email to **KineretONTRACK@AssistRx.com**. Please remember the signature sections **below**
- **To enroll online**, please visit **SobiPatientSupport.iassist.com/HCP**

1 PATIENT AND CAREGIVER INFORMATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ /_____ /_____ Gender: ◯ Male ◯ Female US Resident: ☐ Yes ☐ No Preferred Language: _____

Street: _____ Unit: _____ City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Preferred Contact Method: ◯ Home Phone ◯ Mobile Phone ◯ Text ◯ Email Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

PARENT/CAREGIVER/AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: _____ First Name: _____

Phone: _____ Relationship to Patient: _____

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on page 2.

SIGN HERE **Patient Signature:** _____ **Date:** _____ /_____ /_____

OR

SIGN HERE **Parent/Authorized Representative Signature:** _____ **Date:** _____ /_____ /_____

I am signing on behalf of the patient, and I affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have a valid power of attorney to act on behalf of the patient.

2 INSURANCE INFORMATION Please provide copies of all medical and prescription insurance cards (front and back).

Does the patient have any form of insurance coverage? ◯ Yes ◯ No

Is there a PA on file? ◯ Yes ◯ No (Please include PA determination letter if available.)

Is your patient incurring a lapse in coverage that will cause a lapse in therapy? ◯ Yes ◯ No

Policyholder Full Name: _____ Policyholder Date of Birth: _____ /_____ /_____

Primary Medical Insurance: _____

Insurance Phone: _____ Group #: _____ ID #: _____

Prescription Insurance: _____ RxGroup: _____ RxBIN: _____ RxPCN: _____

Secondary Medical Insurance: _____

Insurance Phone: _____ Group #: _____ ID #: _____

Prescription Insurance: _____ RxGroup: _____ RxBIN: _____ RxPCN: _____

3 PRESCRIBER INFORMATION

Prescriber Last Name: _____ Prescriber First Name: _____

Office Contact Name: _____ Institution Name: _____ Specialty: _____

Medicaid Provider ID #: _____ Tax ID #: _____ NPI #: _____

Address: _____ Suite: _____ City: _____ State: _____ ZIP Code: _____

Office Phone: _____ Ext: _____ Office Fax: _____ Office Email: _____

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.

ICD-10: _____

◯ **I would like my patient and/or his/her parent/caregiver/authorized representative to receive training on the self-administration of Kineret® (anakinra).**

Kineret 100 mg/0.67 mL Solution: ◯ 28 (twenty-eight) Syringes ◯ 7 (seven) Syringes ◯ Other: _____

Directions: Inject: _____ mg, Subcutaneous, Every _____ Refills: _____

Known Allergies: _____

Other Medications (please attach current medication list): _____

SIGN HERE **Prescriber Signature:** _____ **Date:** _____ /_____ /_____

***Stamp signature not allowed.** This form cannot be processed without an original signature.*

☐ **Dispense as written** ☐ **Substitution permitted**

5 PRESCRIBER CERTIFICATION STATEMENT

I hereby attest that I am the prescribing healthcare provider, and I agree to submit requests to Kineret ON TRACK because I have determined that Kineret is medically appropriate for my patient, and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to Kineret ON TRACK for the purpose of providing my patient with assistance in accessing, initiating or continuing Kineret therapy, and/or evaluating my patient's eligibility for patient support programs that may be available, if any.

I certify that the prescription on this form complies with all applicable state and local laws. On behalf of my patient, I authorize Kineret ON TRACK, as my designated agent to forward a prescription for Kineret, by fax or other means under applicable law, to an appropriate pharmacy that dispenses Kineret if necessary.

I agree to notify Kineret ON TRACK if I become aware at any time in the future of changes in my patient's circumstance that would affect their eligibility, including, but not limited to, changes in health insurance status or coverage, financial status or United States residency.

Furthermore, I will not seek reimbursement from any third-party payer or government entity for any product that may be provided free of charge to my patient through a patient support program offered by Kineret ON TRACK.

I acknowledge I may be contacted by email, postal mail, or fax using the information provided on this form, and I understand my information will be used and disclosed by Kineret ON TRACK in accordance with Sobi's privacy policy, available at https://sobi-northamerica.com/privacy-policy.

My signature below certifies that I have read, understand, and agree to the Prescriber Certification Statement.

SIGN HERE **Prescriber Signature:** _____ **Date:** _____ /_____ /_____

***Stamp signature not allowed.** This form cannot be processed without an original signature.*

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6 PREFERRED DELIVERY METHOD

◯ Biologics Specialty Pharmacy ◯ IOD/MID/Institution Name: _____

Phone: _____ Fax: _____

7 KINERET QUICKSTART PROGRAM

The Kineret QuickStart Program can provide a limited supply of Kineret® (anakinra), at no cost, to eligible new patients. Please evaluate my patient for the Kineret QuickStart Program due to the following reason.

◯ I confirm that my patient is new to Kineret and is experiencing an insurance-related delay in coverage.

◯ I confirm my patient has an urgent need to start Kineret within 48 hours so patient can be safely discharged from the hospital or prevent hospital admission.

8 PATIENT AUTHORIZATION STATEMENT

My signature on this form authorizes my doctor(s), healthcare providers, health plan or payer, and my pharmacy to disclose to Sobi Inc. ("Company") and its third-party suppliers, vendors, and other service providers supporting Kineret ON TRACK (collectively, the "Service Providers") information about me (for example, my name, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Protected Health Information and/or Personally Identifiable Information"). This Personally Identifiable Information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my information pursuant to this Authorization.

I understand that Service Providers may be compensated by Sobi. The Service Providers will use and give out my information to (i) assist in my enrollment in Kineret ON TRACK and to contact me and/or the person legally authorized to sign on my behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational material and other information materials related to the Kineret ON TRACK offerings; (iii) verify, investigate, assist with, and coordinate my coverage for Kineret® (anakinra) with my payer; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary and applicable; and (vi) assist with analyses of the efficiencies and performance of services provided by Service Providers.

In some instances, the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This Authorization will last for three (3) years from the date of my signature or until I am no longer receiving Kineret or enrolled in Kineret ON TRACK, whichever is later, unless a shorter period is mandated by state law. I understand that I do not have to sign this Authorization, but if I do not, I may not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of Kineret ON TRACK. My choice as to whether to sign this form will not change the way my doctors, healthcare providers, or payers treat me. If I no longer wish to participate in Kineret ON TRACK, I shall inform Kineret ON TRACK in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel this Authorization, in writing, at any time by providing written notice to Kineret ON TRACK at 495 N Keller Rd, Suite 100, Maitland, FL 32751. Cancellation of this Authorization will be valid when received by the administrators of Kineret ON TRACK. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I know I have a right to see or request a copy of the information my healthcare providers or payers have given to the Service Providers.

If I am being evaluated for assistance under the Kineret Patient Assistance Program (PAP), I agree to allow Service Providers to use my demographic information, including, but not limited to, my Social Security number, date of birth, name, and/or address as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed in reviewing eligibility under the PAP. Service Providers reserve the right to ask for additional documents and information at any time. If I am eligible to participate in the Kineret PAP I understand that: (i) continued enrollment in the PAP is not guaranteed, (ii) re-enrollment is not automatic, (iii) I cannot submit a claim or seek reimbursement or credit for product I receive under the Kineret PAP from my insurance provider or payer, and (iv) no payer, third party, or patient may be charged for PAP product provided under the PAP program. I agree to notify my healthcare providers if I become aware in the future of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residency.

I agree to allow Service Providers to contact me via email or cell phone using the contact information provided in this form, unless I otherwise inform Kineret ON TRACK that I do not wish to receive text messages. I understand that receiving text messages is optional and I can participate in Kineret ON TRACK without agreeing to receive text messages. I understand that by providing my cell phone number on this form I agree to receive text messages with the following conditions:

- Service Providers may send an autodialed pre-recorded text message (standard text message and data rates apply).
- I can opt out at any time by calling 1-866-547-0644 or replying "STOP" to the text messages.
- Service Providers are not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- I am aware that anyone who can open or have access to my phone might see the text messages.
- If my mobile operator is not participating in text messaging services, I will not receive text messages.
- I CANNOT report product complaints or adverse events (like side effects) by text message. To report these, please call Kineret ON TRACK at 1-866-547-0644.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Massachusetts, excluding Massachusetts conflict of law rules, and applicable federal law.