Kineret ON TRACK

# KINERET PATIENT ASSISTANCE PROGRAM APPLICATION

- 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** and on **page 3**
- **To enroll online**, please visit **SobiPatientSupport.iassist.com**

## 1 PATIENT AND CAREGIVER INFORMATION

### PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Date of Birth: ____/____/____

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

Home Phone: _____ Mobile Phone: _____ Email: _____

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

Preferred Language: ◯ English ◯ Spanish ◯ Other: _____ Gender: ◯ Male ◯ Female US Resident: ◯ Yes ◯ No

State where patient is receiving treatment: _____

### CAREGIVER/AUTHORIZED REPRESENTATIVE INFORMATION

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

Home Phone: _____ Mobile Phone: _____ Email: _____

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

Relationship to Patient: I am a *(select one)* ◯ Parent ◯ Caregiver ◯ Advocate

## 2 FINANCIAL INFORMATION

Total annual gross household income $ _____ Include total household number of: Adults (18+) _____ Children _____

**If requested, a patient must provide one of the following financial documents.**

- Federal or State tax return from the most recent tax year
- Pay stubs from the 3 most recent pay periods
- Current W-2
- SSDI/SSI award letter
- 1099 Form

**If no proof of income is available, the patient or parent/caregiver/authorized representative may complete a notarized income statement or provide attestation.**

## 3 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.)

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: _____

## 4 PATIENT/PARENT/CAREGIVER/AUTHORIZED REPRESENTATIVE SIGNATURE

**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.

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REQUIRED **Last Name:** _____ **First Name:** _____ **Date of Birth:** ____ /____ /____

## 5 PATIENT AUTHORIZATION STATEMENT

My signature on this application for the Kineret Patient Assistance Program ("PAP" or "Program"), 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. This information may include, but is 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 my eligibility under the PAP, as well as my medical condition (for example, my diagnosis or medications) (together, "Protected Health Information and/or Personally Identifiable Information"). The Personally Identifiable Information used by Service Providers 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 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. 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 Kineret ON TRACK and other Service Providers may be compensated by Sobi. I understand that Service Providers reserve the right to ask for additional documents and information at any time.

The Service Providers will use and give out my information to (i) assess my eligibility under the Kineret PAP; (ii) enroll me in the Kineret PAP, if I am determined eligible; (iii) provide me and/or the person legally authorized to sign on my behalf with information and educational material; (iv) verify my eligibility for re-enrollment in the Kineret PAP, if applicable; and (v) assist with analyses of the efficiencies and performance of services provided by Service Providers. If I am eligible to participate in the Kineret PAP, I understand that: (i) continued enrollment in the Program 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 Kineret ON TRACK if I become aware 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.

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® (anakinra) or enrolled in the Kineret PAP, 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 choose not to sign this Authorization, Kineret ON TRACK will not be able to evaluate my eligibility for participation under the Kineret PAP.

I agree to allow Service Providers to contact me via email or cell phone using the contact information provided in this application 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 the Kineret PAP without agreeing to receive text messages. I understand that by providing my cell phone number on this application 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.

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REQUIRED **Last Name:** _____ **First Name:** _____ **Date of Birth:** ____ /____ /____

## 6 PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Hospital/Clinic Name: _____

Street: _____ Suite: _____ City: _____ State: _____ ZIP Code: _____

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

Office Contact Name: _____ Phone: _____

Fax: _____ Email: _____

## 7 PRESCRIBER CERTIFICATION STATEMENT

My signature certifies that the person named on this application is my patient: that the information provided to the best of my knowledge is complete and accurate; and that my patient meets the clinical criteria for Kineret® (anakinra) and that therapy with Kineret is medically necessary and I have explained such to my patient. I also certify that I 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 evaluating my patient's eligibility under the Kineret Patient Assistance Program (PAP Program). If my patient is eligible for the PAP Program, I authorize Kineret ON TRACK to forward the prescription to the appropriate pharmacy that dispenses PAP product. 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. I understand that I am under no obligation to prescribe any Sobi products and that I have not received, nor will I receive any benefit from Sobi for doing so. Furthermore, (i) I will not seek reimbursement from any third-party payer or government entity for any product provided under the PAP Program; (ii) I understand that no patient can be charged for product provided under PAP Program, and (iii) that my patient receiving medication under the PAP Program is not contingent upon future purchases or prescribing of Kineret.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. Prescribers in states with official prescription form requirements must submit an actual prescription along with this application. I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my information will be used and disclosed by Kineret ON TRACK in accordance with Sobi's privacy policy, available at www.sobi.com/usa/en/privacy-policy-us.

**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.*

## 8 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.

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

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**

sobi rare strength