Kineret® (anakinra)

Kineret® (anakinra) ON TRACK™

Patient Assistance Program Application

Please complete and sign this application, then fax it to Kineret® ON TRACK™ at 1-866-549-7219.

Additionally, you may be asked to submit the following:

1 Financial information

- Provide total annual gross household income below
- Please provide supporting financial documents
  - — Current federal or state tax return is preferred. If you do not file taxes, alternate documents are acceptable such as current W-2 statement, SSDI/SSI award letter, 1099 form or copy of last 3 pay stubs

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

2 If the patient is insured, please provide a copy of the patient's current insurance and prescription cards (please make a copy of the front and back)

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ Middle Initial: ________

Date of Birth: ______________________ Sex: ◯ Male ◯ Female US Resident: ◯ Yes ◯ No

Street: ______________________ Unit: ________ City: ______________ State: ________ ZIP Code: ____________

Home Phone #: ______________________ Mobile Phone #: ______________________

Email: ______________________ Preferred Contact Method: ◯ Phone ◯ Email

Best Time to Call: ◯ Morning ◯ Afternoon ◯ Evening Preferred Language: ______________________

Total annual gross household income $ ______________ (current annual income includes current salary, Social Security, unemployment benefits, pension, IRA)

Include total household number of: Adults (18+), including self ____________ Children ____________

PARENT/CAREGIVER/AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: ______________________ First Name: ______________________ Phone #: ______________________

Relationship to Patient: ______________________

INSURANCE INFORMATION

Do you have any form of prescription drug coverage? ◯ No ◯ Yes

If Yes, please check all that apply:

◯ Employer-furnished or private insurance ◯ VA or Military benefits ◯ Medicaid State Assistance program for medicines ◯ Medicare Part D

◯ Other prescription coverage ______________________

Plan Name: ______________________ ID #: ______________________ Phone #: ______________________

Have you received a denial letter for Low Income Subsidy application? ◯ No ◯ Yes

If yes, attach a copy of all appeal/denial letters from your insurance company with the application.

IRA=Individual Retirement Account; SSDI=Social Security Disability Income; SSI=Supplemental Security Income; VA=Veterans Affairs.

CONTINUED ON NEXT PAGE

Kineret® (anakinra)

Kineret® (anakinra) ON TRACK™

Patient Assistance Program Application

Patient Last Name: ______________________ First Name: ______________________ Date of Birth: __________

PRESCRIBER INFORMATION

Last Name: ______________________ First Name: ______________________ Middle Initial: __________

Street: ______________________ Suite: ______ City: ______________ State: ______ ZIP Code: __________

NPI #: ______________________ DEA #: ______________________ TAX ID #: ______________________

Medicaid Provider ID #: ____

Office Contact Name: ______________________________ Phone #: ______________________________

Fax #: ______________________________ Email: ______________________________

PRESCRIBER AUTHORIZATION

My signature certifies that the person named on this form is my patient; that the information provided, to the best of my knowledge, is complete and accurate; and that therapy with Kineret is medically necessary. I certify that I have obtained the written authorization of my patient or my patient's parent/caregiver/authorized representative in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Sobi and Kineret ON TRACK patient support program and I understand that the information that I provide on this form will be used by the program for purposes of verifying my patient's insurance coverage and eligibility; coordinating the dispensing of my patient's prescription medicine; and introducing Kineret ON TRACK support services to my patient, including contacting my patient or my patient's parent/caregiver/authorized representative by telephone or mail for these purposes. I authorize Kineret ON TRACK to transmit the above prescription to the appropriate specialty pharmacy for my patient. 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. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by Kineret ON TRACK.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

SIGN HERE Prescriber Signature ______________________________ Date __________

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): ______________________________

Stamp Signature Not Allowed

SIGN HERE Prescriber Signature – Dispense as Written ______________________________ Date __________

OR

Prescriber Signature – Substitution Permitted ______________________________ Date __________

CONTINUED ON NEXT PAGE

Kineret® (anakinra)

Kineret® (anakinra) ON TRACK™

Patient Assistance Program Application

Patient Last Name: ________________________ First Name: ________________________ Date of Birth: ____________

CONSENT FOR ENROLLMENT INTO THE PATIENT ASSISTANCE PROGRAM

By signing this form I allow my or my child's health plans, other payers, pharmacies, and other healthcare providers ("Providers") to share personal and health information related to the need for Kineret ("Information") by the abovenamed patient ("Patient") with Sobi, Inc., and its contractors, agents and distributors (collectively "Sobi") involved with the Kineret ON TRACK Patient Assistance Program to administer the Sobi Kineret Patient Support program and any related Sobi patient-assistance programs for Patient, and to provide to the US Food and Drug Administration, or other government agencies (to comply with state and federal regulation or coverage eligibility requirements). I understand that some healthcare providers and/or pharmacies may receive payment from Sobi or those acting on behalf of Sobi in exchange for disclosing Patient Information to Sobi and/or for providing Patient with support services, including sending communications to me for purposes of the Kineret ON TRACK program.

I understand that if I do not sign this Authorization or later revoke this Authorization, it will not affect Patient's ability to obtain treatment, payment for treatment, or eligibility for or enrollment in benefits. I understand that I am entitled to keep a copy of this Authorization after I sign it. I understand that this Authorization shall remain in effect for five (5) years from the date I sign this Authorization (or such lesser time period as state law may require), unless I revoke it sooner. I may revoke this Authorization at any time by contacting Kineret ON TRACK in writing at AllCare Plus Pharmacy, 50 Bearfoot Rd, Northborough, MA 01532, Attn: Kineret ON TRACK.

I understand that the revocation will be effective when my Providers are notified of it. If I do revoke the Authorization, my Providers can no longer rely on it to make uses and disclosures of Patient Information as described above, but that will not affect any uses and disclosures already made by my Providers in reliance upon this authorization. I understand that once the Patient Information is shared with Sobi based on this Authorization it may be subject to redisclosure by Sobi, and therefore may no longer be protected by federal privacy regulations, but Sobi plans to use and disclose the Patient Information only as described within this Authorization.

Full name (printed) of patient or parent/caregiver/authorized representative ________________________

SIGN HERE **Signature of Patient or Parent/ Caregiver/Authorized Representative** ________________________ **Date** ____________

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 the patient's prescription, and I know that I am responsible for the costs of the patient's care. I also certify that the information I have set forth in this application is true, correct, and complete.

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 the product(s) made available under this program may be denied 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 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 as the information provided is no longer current (ie, 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 this form or confirm other medications that the patient is taking.

- ○ **FAIR CREDIT REPORTING ACT (FCRA) AUTHORIZATION:** I understand that I am providing written instructions authorizing Sobi, Inc. and its vendor, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualification for programs administered by Sobi, Inc. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that Sobi, Inc. is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Sobi, Inc. may revise, change, or terminate programs at any time.

Full name (printed) of patient or parent/caregiver/authorized representative ________________________

SIGN HERE **Signature of Patient or Parent/ Caregiver/Authorized Representative** ________________________ **Date** ____________

CONSENT FOR ENROLLMENT INTO KINERET ON TRACK

By signing below, I am enrolling into Kineret ON TRACK (the "Program"). I authorize Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Sobi, Inc., "Sobi") to provide me and my child with services for which we are eligible under the Program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to enrollment in the copay assistance program if I am eligible.

Full name (printed) of patient or parent/caregiver/authorized representative ________________________

SIGN HERE **Signature of Patient or Parent/ Caregiver/Authorized Representative** ________________________ **Date** ____________

sobi

KINERET and KINERET On TRACK are trademarks licensed by Sobi, Inc. or its affiliates.
©2021 Sobi, Inc. All rights reserved. PP-11547 09/21