Kineret ON TRACK™

KINERET PATIENT ASSISTANCE PROGRAM APPLICATION

- Call **Kineret ON TRACK** at **1-866-547-0644** Monday through Friday 8 AM to 8 PM ET, or visit **Kineretrx.com**
- **Healthcare providers**, please complete this form and fax it to **Kineret ON TRACK** at **1-866-549-7219**, or email to **KineretONTRACK@pharmacord.com**. Please remember the signature sections **below** and on **page 2**

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: ______________ Sex: ◯ 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

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on page 3.

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 FINANCIAL INFORMATION

Please provide supporting 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.

Total annual gross household income $ ______________ Total household number of: Adults (18+) _______ Children _______

3 INSURANCE INFORMATION

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

If the patient is insured, please provide copies of the front and back of the current insurance and/or prescription card(s).

Primary Medical Insurance: ______________ Insurance Phone: ______________

Policyholder Full Name: ______________ Policyholder Date of Birth: _______/_______/_______

Relationship to Patient: ______________ Group #: ______________ Member ID #: ______________

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Last Name: ______________________ **First Name:** ______________________ **Date of Birth:** ____ /____ /____

4 PRESCRIBER INFORMATION

Last Name: ______________________ First Name: ______________________

Hospital/Clinic Name: ______________________

Street: ______________________ Suite: _____ City: ______________ State: _____ ZIP Code: ________

NPI #: ____________ DEA #: ____________ Tax ID #: ____________ Medicaid Provider ID #: ____________

Office Contact Name: ______________________ Phone: ____________

Fax: ______________________ Email: ______________________

5 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**

6 PRESCRIBER CERTIFICATION

My signature certifies that the person named on this application is my patient: that the information provided in this application, to the best of my knowledge, is complete and accurate; and that therapy with Kineret is medically necessary and I have explained such to my patient. I 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 release the individually identifiable health information to Kineret ON TRACK for the purpose of evaluating my patient's eligibility under the Kineret Patient Assistance Program (PAP). If my patient is eligible for the Kineret PAP, I authorize Kineret ON TRACK to transmit the above prescription to the appropriate pharmacy. I agree to notify the Service Providers 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 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 free of charge under the Kineret PAP; (ii) I understand that no patient can be charged for Kineret provided under PAP and (iii) that drug as a part of the Kineret PAP 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 personal 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.*

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Last Name: ______________________ **First Name:** ______________________ **Date of Birth:** ____/____/____

7 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) 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 may be used to estimate my income in conjunction with evaluating my financial eligibility, as well as my overall eligibility, under the Kineret PAP and to enroll me in Kineret ON TRACK. 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 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. 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.

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 continued enrollment in the Program is not guaranteed, and re-enrollment is not automatic. 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.

I understand that I cannot submit a claim or seek reimbursement or credit for product I receive under the Kineret PAP from my insurance provider or payer. No payer, third party, or patient may be charged for PAP product provided under this PAP Program.

This Authorization will last for three (3) years from the date of my signature or until I am no longer 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.

If I receive services offered from Kineret ON TRACK I agree to allow Service Providers to contact me via email or cell phone using the contact information provided in this application. 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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