Enrollment and Prescription Form

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

To prescribe Kineret, please follow these steps:

1. **Have your patient read the Patient Consent Information on page 2 and sign the indicated areas of the Enrollment and Prescription Form. For support in obtaining a patient consent signature, please speak with Kineret® ON TRACK™ at 1-866-547-0644**
2. **Complete the rest of the Enrollment and Prescription Form**
   - Confirm all required information is filled in completely and signed
   - Attach a copy (front and back) of the patient's insurance and drug/prescription benefit cards, including secondary insurance, if applicable
   - Please explain/remind the patient that Kineret ON TRACK will reach out with a welcome call
3. **Fax the Enrollment and Prescription Form to 1-866-549-7219**

If you have any questions or want to learn more about Kineret, please call Kineret ON TRACK at 1-866-547-0644 or visit kineretrx.com.

INSTRUCTIONS FOR PATIENT/PARENT/CAREGIVER/AUTHORIZED REPRESENTATIVE

To get started on Kineret, please follow these steps:

1. **Read the Patient Consent Information and sign the Enrollment and Prescription Form on page 2**
2. **Your healthcare provider will fill out the rest of the form**
3. **You will receive a call from Kineret ON TRACK to discuss the next steps in getting your Kineret prescription filled**
   These calls may come up from an 866 number, "unknown number" or "no caller ID"
4. **Kineret ON TRACK and our partner pharmacies will work with you to have Kineret delivered to you**

If you have any questions, please call Kineret ON TRACK at 866-547-0644, or visit kineretrx.com for more information.

Enrollment and Prescription Form

AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, I authorize my healthcare providers and staff, pharmacies, and health insurers to use and to disclose to Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "Sobi") health information about me or my child related to my or my child's medical condition and treatment, health insurance and coverage, and prescription (including fill/refill information) for Kineret ("Information") to (1) enroll me or my child in and provide services under the Kineret ON TRACK patient-support program ("Program"); (2) obtain information on my or my child's insurance coverage; (3) coordinate prescription fulfillment as indicated by my or my child's physician; (4) provide me with adherence reminders and support; and (5) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Sobi support programs or Sobi products. Once my or my child's Information has been disclosed to Sobi, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Sobi will protect my or my child's Information by using and disclosing it only for the purposes allowed by me or my child in this Authorization or as otherwise required by law.

I understand and agree that the pharmacy that dispenses Kineret may receive payment from Sobi in exchange for disclosing my or my child's Information to Sobi and providing Program services.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my or my child's ability to obtain medical treatment from healthcare providers, payment for treatment or eligibility for health insurance benefits, or access to Sobi medications. However, if I do not sign this Authorization, I understand that I or my child will not be able to participate in the Program.

I understand that this Authorization expires five (5) years from the date signed below, or earlier if required by state or local law, unless and until I cancel (take back) this Authorization before then. I may change my mind and cancel this Authorization at any time by calling 1-866-547-0644 or by notifying Kineret ON TRACK in writing at AllCare Plus Pharmacy, 50 Bearfoot Rd, Northborough, MA 01532. Cancellation of this Authorization will end further uses and disclosures of my or my child's Information by my or my child's healthcare provider and staff, pharmacies, and health insurers based on this Authorization, and my or my child's participation in the Program when they receive notice of my or my child's cancellation, but will not affect any uses or disclosure of my or my child's Information made by my or my child's healthcare providers and staff, pharmacies, and health insurers based on this Authorization before receipt of the cancellation.

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 or 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.

Relationship to patient _____

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

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

Kineret® (anakinra)

Kineret® (anakinra) ON TRACK™

Enrollment and Prescription Form

Fax the Enrollment and Prescription Form to Kineret ON TRACK at 1-866-549-7219.

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: _____

◯ Enroll me or my child into the Kineret Copay Program. Eligibility requirements apply.

◯ I authorize Kineret ON TRACK to leave a detailed message, including my or my child's name or the name of the patient's prescription, Kineret.

PARENT/CAREGIVER/AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: _____ First Name: _____ Phone #: _____ Relationship to Patient: _____

PRESCRIPTION INSURANCE AND MEDICAL INFORMATION

Please attach front and back copy of the patient's insurance and drug/prescription benefit cards (if available). ◯ No Insurance

Primary Medical Insurance: _____ Insurance Phone #: _____

Policyholder Full Name: _____ Policyholder Date of Birth: _____

Realtionship to Patient: _____ Group #: _____ Member ID #: _____

Secondary Medical Insurance: _____ Insurance Phone #: _____

Policyholder Full Name: _____ Policyholder Date of Birth: _____

Realtionship to Patient: _____ Group #: _____ Member ID #: _____

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

PRESCRIBER INFORMATION

Prescriber Last Name: _____ Prescriber First Name: _____ Office Contact Name: _____

Institution Name: _____ Specialty: _____ Tax ID #: _____ NPI #: _____ DEA #: _____

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

Office Phone #: _____ Ext: _____ Office Fax #: _____ Office 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): _____

SIGN HERE _____ **Prescriber Signature – Dispense as Written** **OR** _____ **Prescriber Signature – Substitution Permissible** _____ **Date**

Stamp Signature Not Allowed