Auvi-Q®
epinephrine injection, USP
0.1 mg/0.15 mg/0.3 mg auto-injectors

Kaléo Patient Assistance Program Application

Please fax completed form from prescriber's office to: **(800) 943-1730**

Kaleo, Inc. (Kaléo), the maker of AUVI-Q, understands that some patients may have financial difficulties that prevent them from obtaining necessary medications. Through the Kaléo Patient Assistance Program (PAP), patients who are experiencing financial difficulties may be able to receive AUVI-Q at no cost. As of May 24, 2023 to be eligible for assistance, a patient must:

(1) Have prescription for AUVI-Q;
(2) Be a legal US resident;
(3) Not have any commercial insurance coverage;
(4) Not have any government program insurance coverage; and
(5) Have an annual household income of less than 250% of federal poverty level (for federal poverty levels, visit aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines)

*Required field

1. Patient Information - To Be Completed by Patient

*Patient Name (Last, First):			*SSN:
*Date of Birth (MM/DD/YYYY):	*Weight (lbs):	*Gender: ☐ Male ☐ Female	
*Address (Cannot be a PO Box):	*City	*State:	*Zip:
*Cell Phone: ☐ Text Opt-in‡	Home Phone:	Other Phone:	

‡ I authorize Kaléo and its partners to send me text messages about my AUVI-Q prescription order. Standard message and data rates may apply. To opt out, call 502-213-7601

*Email Address:	If Minor, Parent/Caregiver/Guardian Name (Last, First):
*Do you have commercial insurance? ☐ Yes ☐ No	*Do you have Medicaid, Medicare, or Tricare as your insurance? ☐ Yes ☐ No ☐ N/A
*Number of People in Household:	*Annual Household Income (Patient/Guardian may be required to show proof of income):

By signing below, I affirm and acknowledge that:

- Completing this form does not guarantee I will qualify for benefits of the PAP;
- I allow Kaléo, and the companies working with it to use this registration information to administer any PAP benefits, and contact me about the PAP;
- Kaléo may verify the accuracy of the information on this form;
- Any medicines received through the PAP shall not be sold, traded, bartered or transferred;
- The PAP is not insurance;
- Kaléo reserves the right to change or discontinue the PAP at any time;
- Any PAP benefits are not contingent on any future purchase;
- I am not eligible for prescription drug coverage for AUVI-Q, including but not limited to coverage under Medicaid, Medicare, or Tricare;
- The information I have provided on this form is complete and accurate.

If I receive medicine through the PAP, I also affirm and acknowledge that:

- I will immediately notify Kaléo of any change in my financial status and/or insurance coverage changes by calling 502-213-7601;
- I will not seek reimbursement of any type from my insurance provider for any costs of the medications received; and
- I will notify my insurance provider of the receipt of the medicines.

If I refuse to sign below, I acknowledge that I will not be considered for any benefits of the PAP, but this will not affect my ability to obtain medical treatment, seek payment for medical treatment, or affect my insurance coverage or eligibility.

*Patient's Signature	*Date of Signature

2. Patient Authorization to Share Health Information – To Be Completed by Patient

I agree and consent to allow my healthcare providers and health insurers to give the Kaléo Patient Assistance Program (PAP Program), Kaléo and its agents my personal and medical information, including healthcare condition, diagnosis, and medicines, for the purposes listed below:

- Determine eligibility for the Kaléo PAP.
- Provide me with free medicine through the Kaléo PAP if I am eligible to participate.
- Ensure compliance with laws that may require the use or disclosure of my information.
- Contact me or my healthcare provider for additional information related to any potential reported potential adverse event or product complaint.
- Properly manage, administer, and gather feedback on the Kaléo PAP.

I understand:

- Application to the program is voluntary and I am free to decide whether I would like to sign this form. My decision will not change the way my healthcare providers or health insurers treat me. However, if I do not complete and sign this application, I will not be able to participate in the Kaléo PAP.
- Privacy laws may not prevent further disclosure of my information after it has been provided to the program, Kaléo, their agents, or third-party provider authorized to administer the program.
- My consent to provide my personal and medical information will continue until I am no longer enrolled in the program or until I choose to cancel my consent, which I may do at any time.
- I can cancel my consent at any time by writing to the Kaléo Patient Assistance Program, 2540 Metropolitan Drive, Suite 2546, Trevose, PA 19053, calling 502-213-7601 or faxing 1-800-943-1730. If I cancel my consent, it will not affect the use of information given prior to my cancellation.
- I should keep a copy of this form but can get a copy by contacting the program at 502-213-7601.

*Patient's Signature	*Date of Signature

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For assistance with any questions, call **502-213-7601** • Monday through Friday from 9am to 5pm Eastern Standard Time
For additional information on AUVI-Q, please visit our website **AUVI-Q.com**

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3. Prescriber and Prescription Information - To Be Completed by Prescriber

*Patient Name (Last, First):	*Patient Date of Birth (MM/DD/YYYY):	*Patient Weight (lbs.):	
*Prescriber Name (Last, First):			
*Prescriber Address:	*City:	*State:	*Zip:
*Prescriber's Primary Specialty ☐ Allergy ☐ Pediatrics ☐ Other _____	*NPI:	DEA:	
*Office Contact Name (Last, First):	*Office Phone:	*Office Fax:	

℞ Drug: **AUVI-Q® (epinephrine injection, USP)**

☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg

Dispense as Written: ☐ Yes Quantity: ☐ 1 Carton (2 auto-injectors and 1 trainer)

☐ Sig (Directions): Inject AUVI-Q intramuscularly or subcutaneously into the anterolateral aspect of the thigh, through clothing if necessary. Each device is a single-use injection. PRN for severe allergic reactions, including anaphylaxis, as directed.

☐ Additional/alternate injection instructions (administration, biphasic reaction, etc.):

_____

ICD Diagnosis Code: _____

History of, or at risk for, severe allergic reaction to:
☐ Food
☐ Insect Venom
☐ Medications
☐ Idiopathic
☐ Other: _____

Patient's Current Medications:

_____

Patient's Current Allergies:

_____

Patient's Existing Conditions:

_____

Comments:

*I certify that this AUVI-Q® prescription is medically appropriate for this patient. I give consent to the Kaléo PAP, kaleo, Inc., and its agents, to forward this prescription to a dispensing pharmacy on my, and my patient's behalf.

*Prescriber's Signature	*Date of Signature

AUVI-Q Patient Kit

Scan the QR code to receive a free AUVI-Q educational patient kit

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