Doptelet connect

DOPTELET PATIENT ASSISTANCE PROGRAM APPLICATION

- Call Doptelet Connect™ at **1-833-368-2663** Monday through Friday 8 AM to 8 PM ET, or visit **DopteletConnectHCP.com**
- Please complete and sign this application, then fax it to Doptelet Connect at **1-855-686-8729**

1 PATIENT AND AUTHORIZED REPRESENTATIVE 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 ◯ Email Best Time to Call: ◯ Morning ◯ Afternoon ◯ Evening Sex: ◯ Male ◯ Female

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

AUTHORIZED REPRESENTATIVE INFORMATION

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

Phone: _____ Email: _____

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 authorized representative may complete a notarized income statement or provide attestation.

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

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

Policyholder Full Name: _____ Policyholder Date of Birth: ____ /____ /____

Primary Medical Insurance: _____

Insurance Phone: _____ Group #: _____ ID #: _____

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

4 PATIENT AUTHORIZATION

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement in section 5 on page 2.

SIGN HERE **Patient Signature:** _____ **Date:** ____ /____ /____

OR

SIGN HERE **Authorized Representative Signature:** _____ **Date:** ____ /____ /____

I am signing on behalf of the patient, and I affirm that I have the legal right to do so, through a valid power of attorney to act on behalf of the patient.

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5 PATIENT AUTHORIZATION STATEMENT

My signature on this application for the Doptelet 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 Doptelet Connect (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 Doptelet PAP and to enroll me in Doptelet Connect. 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 Doptelet Connect 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 Doptelet PAP; (ii) enroll me in the Doptelet 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 Doptelet 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 Doptelet 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 Doptelet 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 Doptelet 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, Doptelet Connect will not be able to evaluate my eligibility for participation under the Doptelet PAP.

If I receive services offered from Doptelet Connect 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 Doptelet 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 1-833-368-2663 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 Doptelet Connect at 1-833-368-2663.

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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Patient Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____

6 PRESCRIBER INFORMATION

Last Name: _____ First Name: _____ Office/Institution Name: _____

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

NPI #: _____ Medicaid Provider ID #: _____ Tax 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 in this application, to the best of my knowledge, is complete and accurate; and that therapy with Doptelet 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 Doptelet Connect for the purpose of evaluating my patient's eligibility under the Doptelet Patient Assistance Program (PAP). If my patient is eligible for the Doptelet PAP, I authorize Doptelet Connect to transmit the 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 Doptelet PAP; (ii) I understand that no patient can be charged for Doptelet provided under PAP and (iii) that drug as a part of the Doptelet PAP is not contingent upon future purchases or prescribing of Doptelet.

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 Doptelet Connect in accordance with Sobi's privacy policy, available at www.sobi.com/usa/en/privacy-policy-us.

SIGN HERE **Prescriber Signature** _____ Date: _____ /_____ /_____

Stamp signature not allowed. *This form cannot be processed without an original signature.*

8 CLINICAL INFORMATION Attach any applicable clinical notes.

◯ **Chronic immune thrombocytopenia (ITP) in adult patients**

ITP diagnosis code (ICD-10): D69.3

Other: _____

Prior treatment: _____

_____

_____

◯ **Thrombocytopenia (TCP) in adult patients with chronic liver disease (CLD)**

CLD diagnosis code (ICD-10): _____

TCP diagnosis code (ICD-10): _____

Known procedure date (MM/DD/YYYY): _____

Begin taking (MM/DD/YYYY): _____

Patient platelet count: _____ Allergies: _____ Other medications: _____

9 PHARMACY PRESCRIPTION

The prescriber must comply with his/her state specific prescription requirements, such as e-prescribing, state specific prescription forms, fax language, etc. Noncompliance with state specific requirements may result in outreach to the prescriber.

◯ Doptelet® (avatrombopag) 20-mg tablets 10 ct (NDC # 71369-0020-10)

◯ Doptelet® (avatrombopag) 20-mg tablets 15 ct (NDC # 71369-0020-15)

◯ Doptelet® (avatrombopag) 20-mg tablets 30 ct (NDC # 71369-0020-30)

Directions: _____

Quantity/day: _____ ◯ Refill(s): _____

SIGN HERE **Prescriber Signature** _____ Date: _____ /_____ /_____

Stamp signature not allowed. *This form cannot be processed without an original signature.*

☐ **Dispense as written** ☐ **Substitution permitted**

ICD-10=*International Classification of Diseases, Tenth Edition*; NDC=National Drug Code.

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