Kineret ON TRACK™

PRESCRIPTION AND ENROLLMENT FORM

- 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**

1 PATIENT AND CAREGIVER INFORMATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Sex: ◯ Male ◯ Female US Resident: ◯ Yes ◯ No Preferred Language: _____

Street: _____ Unit: _____ City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Preferred Contact Method: ◯ Home Phone ◯ Mobile Phone ◯ Email Best Time to Call: ◯ Morning ◯ Afternoon ◯ Evening

PARENT/CAREGIVER/AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: _____ First Name: _____

Phone: _____ Relationship to Patient: _____

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

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 INSURANCE 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: _____/_____/_____

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

Secondary Medical Insurance: _____ Insurance Phone: _____

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

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

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

Has a PA Been Submitted? ◯ Yes ◯ No PA Authorization #: _____ Date: _____/_____/_____

3 PRESCRIBER INFORMATION

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

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

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

Office Phone: _____ Ext: _____ Office Fax: _____ Office Email: _____

4 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.

ICD-10: _____

◯ 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**

5 PRESCRIBER CERTIFICATION

I hereby attest that I am the prescribing healthcare provider or an authorized agent in the healthcare provider's practice acting on behalf of the healthcare provider, and I agree to submit requests to Kineret ON TRACK because our medical team has determined that Kineret is medically appropriate for our patient, and we have explained such to our patient. I also certify that this prescription complies with all applicable state and local laws. I certify that I have 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 Service Providers for the purpose of providing access, reimbursement and nursing support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for support.

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. Furthermore, if my patient obtains Kineret via the PAP, I understand that (a) no third-party, or patient can be charged for Kineret provided under PAP and (b) that drug as a part of the PAP is not contingent upon future purchases or prescribing of Kineret.

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:** ____ /____ /____

6 PATIENT AUTHORIZATION STATEMENT

My signature on this enrollment form 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 (for example, my name, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Protected Health Information and/or Personally Identifiable Information"). This Personally Identifiable Information 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 Service Providers may be compensated by Sobi. The Service Providers will use and give out my information to (i) assist in my enrollment in Kineret ON TRACK and to contact me and/or the person legally authorized to sign on my behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational material and other information materials related to the Kineret ON TRACK offerings; (iii) verify, investigate, assist with, and coordinate my coverage for Kineret® (anakinra) with my payer; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary and applicable; and (vi) assist with analyses of the efficiencies and performance of Services provided by Service Providers. I agree to enrollment in the Kineret Copay Assistance Program if I am eligible. 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.

This Authorization will last for three (3) years from the date of my signature or until I am no longer receiving Kineret or enrolled in Kineret ON TRACK, 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 do not, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of Kineret ON TRACK. My choice as to whether to sign this form will not change the way my doctors, healthcare providers, or payers treat me. If I no longer wish to participate in Kineret ON TRACK, I shall inform my healthcare providers and/or the administrators of Kineret ON TRACK in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel this Authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of Kineret ON TRACK at PO Box 5490, 2240 Taylorsville Rd, Suite 1, Louisville, KY 40255. Cancellation of this Authorization will be valid when received by the administrators of Kineret ON TRACK. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I know I have a right to see or request a copy of the information my healthcare providers or payers have given to the Service Providers.

If I am being evaluated for assistance under the Kineret Patient Assistance Program (PAP), I agree to allow Service Providers to use my demographic information, including, but 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), to estimate my income in conjunction with the eligibility determination process performed in reviewing eligibility under the PAP. 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.

If I receive services offered under Kineret ON TRACK, I agree to allow Service Providers to contact me via email or cell phone using the contact information provided in this enrollment form. Receiving text messages is optional and I can participate in Kineret ON TRACK without agreeing to receive text messages. I understand that by providing my cell phone number on this enrollment form 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.