KEPIVANCE Patient Assistance Program Application

Application Instructions

IMPORTANT – PLEASE COMPLETE THIS APPLICATION AND FOLLOW THE INSTRUCTIONS BELOW:

1. **Enclose a valid prescription. (Only faxed prescriptions received directly from the physician's office along with a physician fax cover and valid fax banner can be accepted.)**
2. **Attach Proof of Income (Examples: latest federal or state tax return, latest W-2 statement, SSDI/SSI award letter, last 3 months of bank statements showing income deposits, last 2 pay stubs.)**
3. **If Patient does not have proof of income, patient may complete a notarized income statement or attestation statement form furnished on request by contacting RxCrossroads, 1-866-567-0644.**
4. **PLEASE SUMBIT COPY OF PATIENT'S CURRENT PRESCRIPTION INSURANCE CARDS WITH THIS FORM.**

Physician Information

Physician Name: _____ DEA/State License #/NPI: _____

Hospital/Clinic Name: _____ Specialty: _____

Address: _____

City: _____ State _____ Zip: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

Patient Information

First Name: _____ MI: ___ Last Name: _____ Sex: ☐M ☐F

Email: _____ SSN/ID No: _____ DOB: _____

Address: _____

City: _____ State _____ Zip: _____

Preferred Phone: _____ Alternate Phone: _____

Number of dependents in household (including self): _____ US Resident? ☐Yes ☐No _____

Are you a Veteran of the US Armed Forces? ☐Yes ☐No

Have you received disability payments from Social Security for more than 24 months? ☐Yes ☐No

Allergies: Other Medications:

Insurance Information

Private Prescription Drug Coverage? ☐Yes ☐No

Medicare Part A? ☐Yes ☐No

Medicare Part B? ☐Yes ☐No

Medicare Part D? ☐Yes ☐No

Medicaid? ☐Yes ☐No

Elderly State Drug Assistance? ☐Yes ☐No

Have you received a denial letter for a Low Income Subsidy application? ☐Yes ☐No

AIDs Drug Assistance Program? ☐Yes ☐No

**If yes; please attach a copy with your application.*

Patient Attestation And Signature

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program.

I hereby authorize SOBI, Inc., to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application although SOBI, Inc. is not obligated to verify any of the information contained in Section 1 above or confirm other medications that I am taking.

Original Signature of Patient or Legal guardian (Required to process application)

_____ Date: _____

Fax completed form to 866.549.7219
Phone 866.547.0644

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Prescription Information: *NY prescribers – please submit prescription on an original NY State prescription blank.*
TN prescribers – quantity must be written in both numerals and words. Example: 6 (six) doses

Patient Name:(Required)
Please print legibly

Gender: ☐ Male ☐ Female
Date of Birth (Required):

Patient Weight: ________________ **Kilograms**

Kepivance® (palifermin) 6.25 mg vials **Dispense Qty: ____ Vials**

Directions: ______________________________________

☐ Inject _______mg as directed x _____ doses

☐ Other: ____________________________

Refills: ____________________________

☐ Dispense as written

Prescriber Signature (Required)	Date:

*__TN prescriber's__ quantity must be written in both numerals and words.

***NY prescribers** submit prescription on an original NY State prescription blank.

Patient Certification And Authorization To Disclose Information

By signing below, I allow SOBI, Inc. and other entities involved with PAP/Reimbursement Hotline Program and their employees, distributors or agents, to use and share my health information to administer the medication-access program and any related patient-assistance programs. I also allow my health plans, other payers, pharmacies, and other healthcare providers to give my health information to SOBI, Inc. as needed to help find ways to pay for SOBI, Inc. products, or for treatment or healthcare operations purposes. I agree that my health information may be given to insurance companies, the Food and Drug Administration, or other government agencies (to comply with state and federal regulation or coverage eligibility requirements), charities, or other parties as necessary to participate in the medication-access program and run the program. I know that this program may be changed or stopped at any time. I know that completing this form does not ensure that I will receive therapy. I understand that SOBI, Inc. does not promise to find ways to pay for my prescription, and I know that I am responsible for the costs of my care. I also certify that the information I have set forth in this application is true, correct, and complete.

Original Signature of Patient or Legal guardian (Required to process application)

____ Date: ______________________

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