KERYX PATIENT PLUS
(855) 686-8601
www.auryxia.com

KERYX
BIOPHARMACEUTICALS, INC

Benefits Verification ☐ Complete section A, B, C, and D | **Patient Assistance Program** ☐ Complete section A, B, C, E, F, and G

A) Patient Information *(Mandatory for both)*

First Name:	Middle:	Last Name:	
Date of Birth:	SSN:	Gender: ☐ Male ☐ Female	Diagnosis:
Street Address:	Apt.#:	Email:	
City:	State:	ZIP Code:	Primary Phone:
Patient Representative:	Relation:	Current Treatment: ☐ Hemo ☐ Home Hemo ☐ PD ☐ Non-Dialysis	

B) Provider Information *(Mandatory for both)*

Dialysis Facility Name: Dialysis Facility Tax ID Number:	Prescribing HCP Name: HCP NPI#:
Facility Address: City: State: Zip:	HCP Office Address: City: State: Zip:
Preferred Contact Person:	Preferred Contact Method: ☐ Phone ☐ Email ☐ Fax

Contact Phone:	Contact Email:	Fax:

C) Agreement and Authorization *(Mandatory for both)*

Keryx Patient Plus must have authorization to conduct a benefit verification and insurance research. By providing authorization, the patient ("you" or the "patient") or the patient's healthcare provider ("HCP") permit Keryx Patient Plus and/or its affiliates to contact the insurer(s), including Medicare, about you/the patient's diagnosis and related therapies and allows the insurer(s) to disclose the relevant information about you/the patient to Keryx Patient Plus. Keryx Patient Plus may need to provide the insurer(s) with your/the patient's name, date of birth, Social Security Number, diagnosis, insurance information, or other relevant information about you. Keryx Patient Plus may also contact you or the HCP directly for missing or additional information required to process this verification request.

FOR THE PATIENT: If you understand the foregoing and authorize the sharing of the above information between your dialysis unit, prescribing physician, insurer(s), Medicare, and Keryx Patient Plus, please sign below. By signing below, you also hereby authorize Keryx Patient Plus to contact you directly in the future about available assistance programs, your diagnosis and related therapies, and/or reimbursement and access related information.

FOR THE HCP: I certify and warrant that all patient information supplied to Keryx Patient Plus and/or Keryx Biopharmaceuticals, Inc. affiliates has been obtained pursuant to an appropriate patient authorization allowing for the release, transfer, and use of such information by Keryx Biopharmaceuticals, Inc. in accordance with State and Federal law for verification and/or preauthorization of patient's benefits. I also warrant and represent that I have the full authority to make the certifications and warrants stated above.

Signature (Patient or HCP) ☐ Patient ☐ HCP _____ Date: _____

D) Patient Insurance Information *(Benefits Verification)*

☐ Please attach a copy of the patient's Prescription Benefits card (front & back copy)

Does the patient have any Prescription Drug Coverage? ☐ Yes ☐ No	Does the patient have Medicare Coverage? ☐ Yes ☐ No Does the patient have Medicaid Coverage? ☐ Yes ☐ No
If Yes: Medicare Policy ID:	Effective Date:

E) Patient Financial Information *(Patient Assistance Program)*

Is the patient a U.S. citizen? ☐ Yes ☐ No If No, is the patient a permanent resident of the U.S.? ☐ Yes ☐ No	Total Household Size (including patient): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Total Annual Adjusted Gross Income for your Entire Household (before taxes): $
(Includes all annual income wages, pension, social security, disability, alimony, interest/dividends, rental property income, etc.)

F) Prescription Information *(Patient Assistance Program)*

Is the patient currently on dialysis? ☐ Yes ☐ No	
Select Medication: ☐ **AURYXIA™ (ferric citrate)** Diagnosis Code: Ship to: ☐ Patient ☐ Facility ☐ Prescribing HCP	Sig/Directions: Quantity: # of Refills:
Print Prescriber Name:	HCP State License #:

Prescriber Signature _____ Date: _____

G) Patient Agreement and Authorization *(Patient Assistance Program)*

I know that to qualify for free medicine, my household adjusted gross income must be at or below 300% of the Federal Poverty Level and I certify that the patient financial information I have provided is correct. I certify I have no health plan coverage for AURYXIA™ (ferric citrate). This includes Medicare, Medicaid or other public programs. I do not have the resources to pay for AURYXIA™ (ferric citrate). I agree to provide Keryx Patient Plus proof of my income, if requested. I agree that if my certification about my income is false, I will reimburse Keryx Biopharmaceuticals.

Patient Signature _____ Date: _____

Please return the completed application form and required documentation to: Keryx Patient Plus, P.O. Box 877, Somerville, NJ 08876
Phone: (855) 686-8601 Fax: (866) 310-7424 Email: KPP@keryx.com

KERYX PATIENT PLUS

Guidance for completing the Keryx Patient Plus Form

Please identify whether you are requesting Benefits Verification or enrollment in the Patient Assistance Program. Please complete the sections identified to the best of your ability. Missing or incorrect information may result in the form being "kicked back" for revision, and thus delay in potential assistance for your patients.

Benefits Verification: complete sections A, B, C, and D

Patient Assistance Program: complete sections A, B, C, E, F, and G

Section A. Patient Information:

This information is mandatory for both the Benefits Verification and enrollment for the Patient Assistance Program. Please provide the patient's primary phone (can be home, cell, or work phone number). The Patient Representative Phone number is optional, but useful if they are the primary caretaker and/or if it differs from the patient's phone number.

Section B. Provider Information:

This information is mandatory for both the Benefits Verification and enrollment for the Patient Assistance Program.

Section C. Agreement and Authorization:

This information is mandatory for both. Either the patient's signature or an HCPs is required to confirm all information provided is accurate, and to authorize Keryx Patient Plus to complete the Benefits Verification on their behalf.

Section D. Patient Insurance Information:

Benefits Verification only. Please note that if you include a copy of the front and back side of the patient's Prescription Benefits card, you do not need to fill out this section. Keryx Patient Plus will use this information to conduct the benefits research, investigate the need for prior authorization and determine co-pay amounts.

Section E. Patient Financial Information:

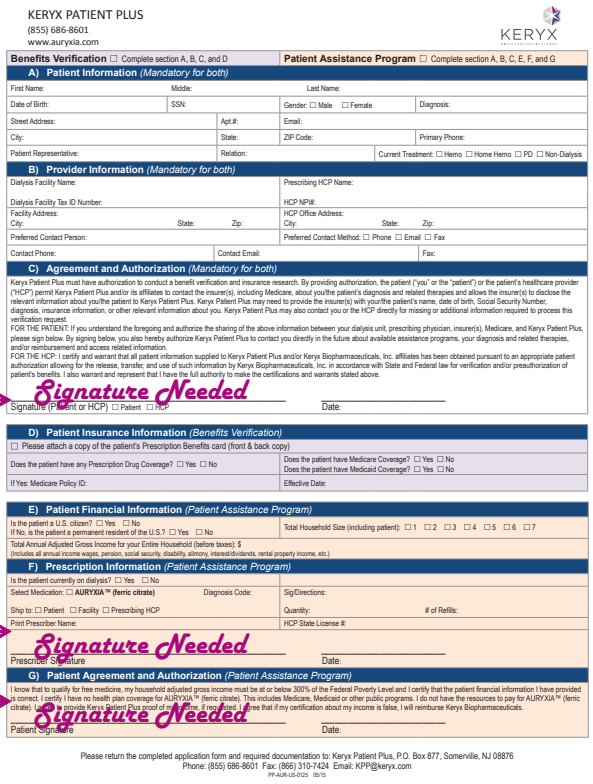
Patient Assistance Program only. This document serves as a sworn statement of income. No formal documentation is necessary. Eligible patients must be US citizens, or legal residents who are classified as low income (≤300% of the Federal Poverty Level).

Section F. Prescription Information:

Patient Assistance Program only. This section requires the Prescriber to initiate the prescription for AURYXIA™ (ferric citrate). Crucial to this prescription is the Prescriber's signature authorizing Keryx Patient Plus to transmit the prescription to the appropriate dispensing pharmacy.

Section G. Patient Agreement and Authorization:

Patient Assistance Program only. This section requires the patient's signature to attest to the financial information being provided.



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Benefits Verification ☐ Complete section A, B, C, and D
Patient Assistance Program ☐ Complete section A, B, C, E, F, and G

A) Patient Information *(Mandatory for both)*

First Name: Middle: Last Name:
Date of Birth: SSN: Gender: ☐ Male ☐ Female Diagnosis:
Street Address: Apt.#: Email:
City: State: ZIP Code: Primary Phone:
Patient Representative: Relation: Current Treatment: ☐ Hemo ☐ Home Hemo ☐ PD ☐ Non-Dialysis

B) Provider Information *(Mandatory for both)*

Dialysis Facility Name: Prescribing HCP Name:
Dialysis Facility Tax ID Number: HCP NPI#:
Facility Address: HCP Office Address:
City: State: Zip: City: State: Zip:
Preferred Contact Person: Preferred Contact Method: ☐ Phone ☐ Email ☐ Fax
Contact Phone: Contact Email: Fax:

C) Agreement and Authorization *(Mandatory for both)*

Keryx Patient Plus must have authorization to conduct a benefit verification and insurance research. By providing authorization, the patient ("you" or the "patient") or the patient's healthcare provider ("HCP") permit Keryx Patient Plus and/or its affiliates to contact the insurer(s), including Medicare, about you/the patient's diagnosis and related therapies and allows the insurer(s) to disclose the relevant information about you/the patient to Keryx Patient Plus. Keryx Patient Plus may need to provide the insurer(s) with your/the patient's name, date of birth, Social Security Number, diagnosis, insurance information, or other relevant information about you. Keryx Patient Plus may also contact you or the HCP directly for missing or additional information required to process this verification request.
FOR THE PATIENT: If you understand the foregoing and authorize the sharing of the above information between your dialysis unit, prescribing physician, insurer(s), Medicare, and Keryx Patient Plus, please sign below. By signing below, you also hereby authorize Keryx Patient Plus to contact you directly in the future about available assistance programs, your diagnosis and related therapies, and/or reimbursement and access related information.
FOR THE HCP: I certify and warrant that all patient information supplied to Keryx Patient Plus and/or Keryx Biopharmaceuticals, Inc. affiliates has been obtained pursuant to an appropriate patient authorization allowing for the release, transfer, and use of such information by Keryx Biopharmaceuticals, Inc. in accordance with State and Federal law for verification and/or preauthorization of patient's benefits. I also warrant and represent that I have the full authority to make the certifications and warrants stated above.

Signature Needed
Signature (Patient or HCP) ☐ Patient ☐ HCP Date:

D) Patient Insurance Information *(Benefits Verification)*

☐ Please attach a copy of the patient's Prescription Benefits card (front & back copy)

Does the patient have any Prescription Drug Coverage? ☐ Yes ☐ No
Does the patient have Medicare Coverage? ☐ Yes ☐ No
Does the patient have Medicaid Coverage? ☐ Yes ☐ No
If Yes: Medicare Policy ID: Effective Date:

E) Patient Financial Information *(Patient Assistance Program)*

Is the patient a U.S. citizen? ☐ Yes ☐ No
If No, is the patient a permanent resident of the U.S.? ☐ Yes ☐ No
Total Household Size (including patient): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
Total Annual Adjusted Gross Income for your Entire Household (before taxes): $
(Includes all annual income wages, pension, social security, disability, alimony, interest/dividends, rental property income, etc.)

F) Prescription Information *(Patient Assistance Program)*

Is the patient currently on dialysis? ☐ Yes ☐ No
Select Medication: ☐ **AURYXIA™ (ferric citrate)** Diagnosis Code: Sig/Directions:
Ship to: ☐ Patient ☐ Facility ☐ Prescribing HCP Quantity: # of Refills:
Print Prescriber Name: HCP State License #:

Signature Needed
Prescriber Signature Date:

G) Patient Agreement and Authorization *(Patient Assistance Program)*

I know that to qualify for free medicine, my household adjusted gross income must be at or below 300% of the Federal Poverty Level and I certify that the patient financial information I have provided is correct. I certify I have no health plan coverage for AURYXIA™ (ferric citrate). This includes Medicare, Medicaid or other public programs. I do not have the resources to pay for AURYXIA™ (ferric citrate). I will provide Keryx Patient Plus proof of income if requested. I agree that if my certification about my income is false, I will reimburse Keryx Biopharmaceuticals.

Signature Needed
Patient Signature Date:

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