KINERET® Patient Assistance Program
Application

Kineret® (anakinra) On TRACK™

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 the KINERET On TRACK program, 1-866-567-0644.**
4. **PLEASE SUBMIT COPY OF PATIENT'S CURRENT PRESCRIPTION INSURANCE CARD WITH THIS FORM.**

Prescriber 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

AIDS Drug Assistance Program? ☐Yes ☐No

Have you received a denial letter for a Low Income Subsidy application?* ☐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 and 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

RE-SOB-006-A

sobi SWEDISH ORPHAN BIOVITRUM

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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: 3 (three) doses*

Patient Name (Required. Please print legibly): _____	**Gender:** ☐ **Male** ☐ **Female** **Date of Birth (required):** _____

KINERET® 100 mg/0.67mL Solution ☐ **28 Syringes** ☐ **7 Syringes** ☐ **Other:** _____

Directions: Inject _____ **mg subcutaneously every** _____

Refills: _____

☐ **Dispense as written**

Prescriber Signature (Required)	**Date:**

***TN Prescribers:** 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 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's 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: _____

Fax completed form to 866.549.7219
Phone 866.547.0644

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