

Sponsor Form A

Instructions: This form should be completed by a Sponsor or a Kepivance[®] Patient Assistance Program Specialist (only once per Sponsor).

1. Sponsor (Facility) Information

Sponsor (Facility) Name _____
Contact Person _____
Title _____
Address _____
City _____ State _____ Zip _____
Phone Number _____ Fax _____

If your facility is part of a chain or group-purchasing organization, please list the name:

Please indicate if the sponsor is a: _____ Physician Office _____ Hospital/Hospital Pharmacy* _____ Community/Specialty Pharmacy
_____ Dialysis Center: _____
_____ Hospital-Based _____ Home Dialysis _____
_____ Free-Standing _____ Supplier _____ Home Health Care _____ Transplant Center*
_____ Infusion Center

Physician/Facility License Number _____

*The Kepivance[®] Patient Assistance Program cannot provide assistance for inpatient hospital use.

2. Product Shipping Information

Confirm address where product should be shipped (if different than above).

Sponsor (Facility) Name _____
Contact Person _____
Title _____
Address _____
City _____ State _____ Zip _____
Phone Number _____ Fax _____

3. Sponsor Certification and Consent

By submitting this application, I agree to the following:

- I will provide Biovitrum products for patients in a medically appropriate manner based on current standards of medical care.
- I understand that Biovitrum reserves the right to change or terminate this program at any time, or to refuse to distribute Biovitrum products under this program to any patient or sponsor.
- I understand that product is provided on a replacement basis. Participating providers are required to stock the product and apply for replacement product through the Kepivance® Patient Assistance Program.
- I understand that an insurance verification may be required to determine a patient's eligibility for the Kepivance® Patient Assistance Program.
- I understand that the product received through the Kepivance® Patient Assistance Program is for medically needy patients living in the United States and its territories.
- I certify that no third party or patient has been or will be charged for Biovitrum products for which replacement is sought from Biovitrum under the Kepivance® Patient Assistance Program. I further certify that all product received in connection with the Kepivance® Patient Assistance Program will replace such product; be furnished free of charge for treatment of needy patients who meet Kepivance® Patient Assistance Program criteria; and, that no part of any charges for Biovitrum products replaced under the Kepivance® Patient Assistance Program will be claimed as bad debt on any of _____ cost reports.
- I understand that Biovitrum's Kepivance® Patient Assistance Program is available for outpatient use only. I certify that no replacement will be requested for product administered in the hospital inpatient setting.
- If I become aware of any changes in the patient's circumstances that affect Kepivance® Patient Assistance Program eligibility, I agree to notify the Kepivance® Patient Assistance Program immediately.
- I agree to release or make available to an authorized Biovitrum representative the medical and financial records for Kepivance® Patient Assistance Program patients at any time for the sole purpose of verifying patients' eligibility for the Kepivance® Patient Assistance Program, and I agree to obtain appropriate consent from each patient prior to releasing or making available to Biovitrum such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

Sponsor Signature _____ Date: _____

Title _____

Send completed forms to: Kepivance® Patient Assistance Program
 PO Box 13185
 La Jolla, CA 92039-3185
 Tel: 866.547.0644
 Fax: 866.549.7219