



Kepivance® Patient Assistance Program

Phone: 866-547-0644

Fax: 866-549-7219

Form B Instructions

Thank you for your interest in enrolling your patient into the Kepivance® Patient Assistance Program. The Program is a non-profit program that helps needy patients obtain access to Kepivance®.

To apply for the Program:

1. Make sure your facility is enrolled as a Kepivance® Patient Assistance Program Sponsor via Form A (Sponsor Enrollment Form – only needs to be completed once upon Sponsor’s initial enrollment into the Program).
2. Fill out the sponsor, patient, and physician information on the enclosed Form B (Patient Enrollment Form).
3. Obtain required signatures on Form B:
 - sponsor contact signature – signature of contact authorized to sign on behalf of your facility;
 - and**
 - patient signature
4. Provide family size on Form B (include number of people in household).
5. Provide proof of patient’s household income along with Form B. You may submit any **one** of the following:
 - latest federal or state tax return,
 - latest W-2 statement,
 - SSDI/SSI award letter,
 - bank statements (last 3 months showing income deposits),
 - pay stubs (last 2 pay stubs), **or**
 - state program acceptance letter or card (e.g. ORSA).

If the patient does not have proof of income, you may complete **one** of the following forms:

- notarized income statement (form enclosed), **or**
- attestation statement with two signatures (form enclosed).

6. Fax or mail the completed Form B and proper income documentation to:

**Kepivance® Patient Assistance Program
PO Box 66982
St. Louis, MO 63166-6982
Tel: 866-547-0644
Fax: 866-549-7219**

For any questions please call 866-547-0644, Monday through Friday, 8 a.m. to 6 p.m. Eastern Time.

Sincerely,

Kepivance® Patient Assistance Program

NOTARIZED INCOME STATEMENT

Only use this form if you cannot provide proof of income documentation.

Name: _____ **SS#:** _____ **Date of Birth:** _____

My estimated annual household income currently is \$_____.

(Please include dollar amount)

- \$_____ Social Security Disability Income (SSDI) (Beginning __/__)
- \$_____ Supplemental Security Income (SSI)
- \$_____ Aid from the Department of Public Welfare
- \$_____ Unemployment Benefits (From __/__ to __/__)
- \$_____ Workers Compensation Benefits (From __/__ to __/__):
- \$_____ Dividends, interest, or investment accounts
- \$_____ Employment (Myself and/or my spouse)
- \$_____ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Family Size: _____

(include number of people in household)

**YOU MUST HAVE THIS FORM NOTARIZED IN ORDER TO PREVENT A DELAY
IN THE PROCESSING OF YOUR APPLICATION.**

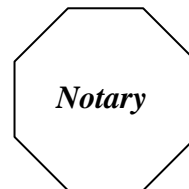
Patient Signature _____

Notary Seal

Date _____

Notary Signature _____

Date _____



ATTESTATION FORM

Only use this form if you cannot provide proof of income documentation.

Name: _____ **SS#:** _____ **Date of Birth:** _____

My estimated annual household income currently is \$_____.

(Please include dollar amount)

- \$_____ Social Security Disability Income (SSDI) (Beginning __/__)
- \$_____ Supplemental Security Income (SSI)
- \$_____ Aid from the Department of Public Welfare
- \$_____ Unemployment Benefits (From __/__ to __/__)
- \$_____ Workers Compensation Benefits (From __/__ to __/__)
- \$_____ Dividends, interest, or investment accounts
- \$_____ Employment (Myself and/or my spouse)
- \$_____ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Family Size: _____

(include number of people in household)

Sponsor Contact Attestation:

Sponsor contact may sign below to attest to the patient's financial situation.

To the best of my knowledge, I know the financial information provided on this application to be true.

Print Sponsor Contact Name: _____

Sponsor Contact Title: _____

Original Sponsor Contact

Signature: _____ **Date:** _____

(Stamps not accepted)

Patient

Signature: _____ **Date:** _____

Form B

Patient Enrollment Form (p) 866-547-0644

Instructions: This form should be used to assess Kepivance® Patient Assistance Program eligibility for Kepivance®. For assistance in completing this application, please call 866-547-0644. Sponsors must contact the hotline or submit this form to begin enrollment of a patient in the Kepivance® Patient Assistance Program. Information supplied on this form will be strictly confidential.

1. Sponsor (Facility) Mailing Information*

Sponsor (Facility)
Name _____

Contact Person _____

Sponsor
Address _____

Phone Number _____ Fax _____

Kepivance® Patient Assistance Program
Sponsor Number _____

Facility Customer
Number _____

Email
Address _____

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

2. Patient Information

Patient
Name _____

Kepivance® Patient Assistance
Program Case Number (if available) _____

Social Security
Number _____

DOB

Is the Patient a US Citizen or
Resident? _____ Yes _____ No

Form B - Patient Enrollment Form

Patient Name _____

3. Physician Information

Physician Name _____

Physician Address _____

Physician State _____ Email _____
License Number _____ Address _____

4. Patient Allergy Information

Patient Drug Allergies (check all that apply):

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Tetracyclines |
| <input type="checkbox"/> No Known Allergies | <input type="checkbox"/> Other: _____ | | |

5. Financial/Insurance Information

- Income: Patient's annual household income: _____
- Family Size (**required**): include applicant & number of dependents on Federal income tax return: _____
- Insurance: Please check all insurers from which this patient qualifies for benefits:

<u>Insurer*</u>	<u>Status</u>				<u>Date</u>
Medicare Part B	___ Yes	___ No	___ Pending	___ Denied	Effective Date _____ Plan Name & Effective Date _____
Medicare Part D Medicare Part D	___ Yes	___ No	___ Pending	___ Denied	Effective Date _____
Medicaid	___ Yes	___ No	___ Pending	___ Denied	Effective Date _____
VA/DoD	___ Yes	___ No	___ Pending	___ Denied	Effective Date _____
Commercial	___ Yes	___ No	___ Pending	___ Denied	Effective Date _____
Name of Commercial Health Insurer	_____ «comm name» _____				
Other Health Insurance	___ Yes	___ No	___ Pending	___ Denied	Effective Date _____
Name of Other Health Insurer	_____				

* An insurance verification may be required to determine the patient's eligibility for the Kepivance® Patient Assistance Program.

6. Patient Consent Statement

My doctor has prescribed Biovitrum products for me and I would like to receive the drug free of charge through the Kepivance® Patient Assistance Program. In order to participate, I hereby certify that the financial/insurance information listed above is accurate. I agree that this information can be provided to the Program, Biovitrum, and any agent of Biovitrum or the Program authorized to perform services on behalf of the Program.

I understand that, in order to determine my eligibility to participate in the Program, the Program needs information about my family income, and my health insurance. I agree to permit information about me to be provided to the Program, Biovitrum, and any agent of Biovitrum or the Program authorized to perform services on behalf of the Program, which will include a verification of my coverage with my insurance company, and to update my records to show that I continue to qualify for the Program. I further authorize the Program to provide Biovitrum with information concerning any assistance provided to me by the Program.

I also understand that my information may be provided to clinicians, social workers, and family members if reasonably necessary to complete the application or coordinate assistance. I understand that my assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that the Program reserves the right at any time, and without notice, to modify the application form; modify or discontinue this Program and its eligibility criteria; or terminate assistance.

Form B - Patient Enrollment Form

Patient Name _____

- I would like to receive Biovitrum products free of charge from the Kepivance® Patient Assistance Program. I do not have, nor am I eligible for, any private or public health insurance other than that listed above. I do not have, nor am I eligible for, any other form of public assistance with my medical expenses.
- I certify that I will not request reimbursement from any insurance carrier or government health benefit program for any Biovitrum products I receive from the Program.
- I certify that the above information is correct to the best of my knowledge. I understand that this information will not be used for any other purpose unless I give written consent, the government requires it, or the Kepivance® Patient Assistance Program removes my name and any other identifying information.
- I understand that the Kepivance® Patient Assistance Program may change or stop this program with respect to any patient, or in its entirety, at any time. I also understand that, although Biovitrum products may be given to me free of charge now, this does not mean I will be entitled to receive it free of charge indefinitely.
- I will not sell, trade, or distribute Biovitrum products given to me by the Kepivance® Patient Assistance Program.
- I understand that The Safety Net Program and such distributor as the Program may designate, may need to obtain my medical records from my physician and related information, including but not limited to my name, Social Security number, address, and date of birth, in order to assure continuity of care and in order for me to receive Biovitrum products. I authorize my physician to release to the Program all medical records and related information that may be necessary or helpful to the provision of Biovitrum products. I also authorize the Program, and its agents, to release medical information and related information to each other for purposes of my health care and in order for me to receive Biovitrum products. A photocopy of this authorization will be as valid as the original.
- I understand that the Kepivance® Patient Assistance Program, or an agent of the Program, may need to work with my social worker or other agent to case manage and coordinate care on my behalf.

This consent expires the latter part of 1 year after the date of execution or 1 year after the last date I receive product under the Program. I understand that this information identifying me will not be used for any purpose other than for the Program unless: (i) I give written consent, (ii) such disclosure is required by the government, or (iii) my name and any other identifying information are first removed.

Type or print name of patient

Date

Type or print name of legal representative (if applicable)

Witness signature

Signature of patient or legal representative

7. Physician Certification Statement

I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the Kepivance® Patient Assistance Program of any changes that I become aware of, which could affect the patient's eligibility status.

I represent that I am duly authorized and have legal capacity to execute and deliver this form on behalf of the Sponsor.

Sponsor Facility Name: _____

Signature of Authorized Representative: _____ Date _____

Patient Name

Authorized Representative Name: _____

Title _____

Send completed forms to: **The Kepivance® Patient Assistance Program**
PO Box 66982
St. Louis, MO 63166-6982
Tel: 866-547-0644
Fax: 866-549-7219