

Kineret[®] and Kepivance[®]
Patient Assistance Program
 P.O. Box 66982 St. Louis, MO 63166-6982
 Phone: 1-866-547-0644 Fax: 1-866-549-7219
 P.O. Box 66982 St. Louis, MO 63166-6982

Form C: Prescription and Order Form

Section 1 - Physician and Prescription Information				
Physician Name:	DEA/State License #/NPI:	Phone: ()	Fax: ()	
Address: (No P.O. Box)		City:	State:	Zip:
Product Requested	Instructions	Quantity in Boxes	Day supply	Refills
Kepivance* <input type="checkbox"/> 6 vials per box			One course of therapy	No refills allowed
<i>Kepivance must be shipped to the physician's address</i>				
Physician Signature: <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> <input type="checkbox"/> _____ <small>(substitution allowed)</small> </div> <div style="text-align: center;"> / / <small>(date)</small> </div> <div style="text-align: center;"> <input type="checkbox"/> _____ <small>(dispense as written)</small> </div> </div>				
Section 2 - Patient Information				
Patient Name:		SS #, Green Card, VISA:		
Street Address:		Date of Birth:	ICD-9 Code	
City:	State:	Zip:	Phone: ()	
Medication Information				
Patient allergies: <input type="checkbox"/> No Known _____				
Please list the names of other medications the patient is currently taking: <input type="checkbox"/> None _____				

Please fax this form to 1-866-549-7219 or mail to address above
If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form.

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

By submitting this request I agree to the following:

- I certify that the Biovitrum product reported on this form, for which I am requesting free replacement, was furnished free of charge to a Kepivance Patient Assistance Program patient. I represent that the information provided in this form is complete and accurate to the best of my knowledge and agree to notify the Kepivance Patient Assistance Program of any changes I become aware of which could affect patient eligibility. I further certify that I am authorized to act for the institution for which I am signing.
- I certify that no replacement will be requested for product administered in the hospital inpatient setting.