

## The Kineret® & Kepivance® Patient Assistance Program

### **Instructions**

The Kineret® and Kepivance® Patient Assistance Program provides temporary product assistance to financially needy patients who meet predetermined eligibility criteria. To receive free product, the prescriber and patient must complete a Kineret® Patient Assistance Program Application.

To obtain an application or to initiate the application process, please call the Kineret® and Kepivance® Patient Assistance Program at 866-574-0644. Counselors are available Monday through Friday, 8:00 a.m. to 6:00 p.m., Eastern Time.

To apply for the Program, patients and their physicians should complete the following:

### **1. Patient Portion** –

- The patient must complete Form B: Patient Form in its entirety.
- The Form B includes required demographic, insurance, and financial information. The patient is required to sign the Application Declaration.
- Provide proof of income. The patient 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).
- By signing this form, the patient provides authorization for their provider to disclose the information requested in Form A of the application.
- Form B should be completed by the patient, and a copy should be given to the provider for their records.

### **2. Physician Portion** –

- The patient's physician must complete Form A: Physician Portion in its entirety.
- General provider and prescription information is required.
- In addition, the physician's state license number (SLN) is required on Form A.
- The provider is required to sign the Physician Declaration.

**Instructions, continued.**

- **Physician office staff may mail or fax the completed application (Patient Form [Form B], Physician Form [Form A], and proper income documentation) to:**

**The Kineret® and Kepivance® Patient Assistance Program  
PO Box 66982  
St. Louis, MO 63166-6982  
Tel: 866-574-0644  
Fax: 866-549-7219**

Faxed copies of applications are accepted, but must be sent from the physician's office. Once we receive a complete application, both patient and physician will be notified of patient's eligibility. For any questions please call 866-574-0644, Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern Time.

Sincerely,

The Kineret® and Kepivance® Patient Assistance Program

**Kineret<sup>®</sup> and Kepivance<sup>®</sup>**  
**Patient Assistance Program**  
 P.O. Box 66982 St. Louis, MO 63166-6982  
 Phone: 866-547-0644 FAX: 866-549-7219  
 P.O. Box 66982 St. Louis, MO 63166-6982

## Form A: 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:
Prescription	Instructions	Quantity in Boxes	Day Supply	Refills
<b>Kineret 100mg</b> <input type="checkbox"/> 28 vials per box			56 days per shipment	
<i>Kineret may be shipped to patient's address or healthcare provider's office; if not indicated Kineret will be shipped to patient's address.</i>				
Kineret should be sent to: Licensed Prescriber's Office <input type="checkbox"/> Patient's Address <input type="checkbox"/>				
Product Requested	Instructions	Quantity in Boxes	Day supply	Refills
<b>Kepivance</b> <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>				
<b>Physician Signature:</b> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <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:  No Known \_\_\_\_\_

Please list the names of other medications the patient is currently taking:  None \_\_\_\_\_

**Please fax this form to 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.**

Completion of this form is part of the initial application process and does not guarantee enrollment in the Kineret® and Kepivance® Patient Assistance Program. The Program will review the completed application to determine the patient's eligibility.

**Form B: PATIENT FORM**

**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.)

**Number of People in Household:** \_\_\_\_\_

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

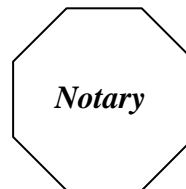
Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Notary Signature \_\_\_\_\_

Date \_\_\_\_\_

Notary Seal



**Form B: PATIENT FORM**

**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.)

**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 Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Original Signature:** \_\_\_\_\_  
(Stamps not accepted) **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Form B: PATIENT FORM**

**The Kineret® Patient Assistance Program Application**

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A." Return this completed confidential application to the address or fax number above. The application process can be initiated based on receipt of a faxed application and prescription.

**Patient Information**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F  
 Social Security Number: \_\_\_\_\_ Is the Patient a US Citizen or Resident? Yes No  
 Phone (Day): \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**Physician Information**

Physician Name: \_\_\_\_\_ State License Number: \_\_\_\_\_  
 Contact Person (other than physician): \_\_\_\_\_  
 Facility/Practice Name: \_\_\_\_\_  
 Address (no PO boxes please): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

**Financial Information**

Current annual household gross income \$ \_\_\_\_\_ Household size (required) - include applicant & number of dependents on Federal income tax return: \_\_\_\_\_

<p><b><u>Patient Insurance Coverage: Primary Coverage</u></b></p> <p><input type="checkbox"/> Commercial <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> VA/DOD  <input type="checkbox"/> State Kidney Program <input type="checkbox"/> Other Insurer (explain): _____</p> <p>Insurance Company Name: _____        Policy Holder Name: _____        Policy Holder's Date of Birth: _____        Policy ID Number: _____        Group Number: _____        Effective Date: _____        Insurer Telephone: ( ) _____</p>	<p><b><u>Patient Insurance Coverage: Secondary/Supplemental Coverage</u></b></p> <p><input type="checkbox"/> Commercial <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> VA/DOD  <input type="checkbox"/> State Kidney Program <input type="checkbox"/> Other Insurer (explain): _____</p> <p>Insurance Company Name: _____        Policy Holder Name: _____        Policy Holder's Date of Birth: _____        Policy ID Number: _____        Group Number: _____        Effective Date: _____        Insurer Telephone: ( ) _____</p>
<p><b><u>Prescription Coverage: (under Primary)</u></b></p> <p>Prescription Benefit Name: _____        Telephone : ( ) _____</p>	<p><b><u>Prescription Coverage: (under Secondary/Supplemental)</u></b></p> <p>Prescription Benefit Name: _____        Telephone : ( ) _____</p>
<p>ENTER MEDICARE COVERAGE DETAILS (please circle):        Medicare Part A: Yes N/A Denied Pending Effective: _____        Medicare Part B: Yes N/A Denied Pending Effective: _____        Medicare Part D: Yes N/A Denied Pending Effective: _____        Part D Plan Name: _____        Telephone: ( ) _____</p>	<p>Copay/Premium Assistance Program Screening: <u>Have you applied for and received co-payment or premium funding assistance?</u> Yes: ___ No: ___        If yes, list amount and status of award: _____        _____        Copay Award Status: <input type="checkbox"/> Pending Award <input type="checkbox"/> Exhausted Funding  <input type="checkbox"/> Denied Funding <input type="checkbox"/> Receiving Funding</p>

Please indicate all sources of income by checking the appropriate box(es) below: Employment Social Security (SS) Benefits

Supplemental Security Income (SSI)  Social Security Disability Income (SSDI)  Other (explain): \_\_\_\_\_

**Form B: PATIENT FORM**

Patient's Name: \_\_\_\_\_

**Application Declaration**

My doctor has prescribed the applicable prescription drug for me and I would like to receive the drug free of charge through The Kineret® and 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 given to the Program, HealthBridge, and Biovitrum to support my application, 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.

- I would like to receive Kineret® free of charge from the Kineret® and 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 Kineret® 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 Kineret® and Kepivance® Patient Assistance Program removes my name and any other identifying information.
- I understand that the Kineret® and 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 Kineret® 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 Kineret® given to me by the Kineret® and Kepivance® Patient Assistance Program.
- I understand that the Kineret® and Kepivance® Patient Assistance Program and HealthBridge, or such other 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 Kineret®. 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 Kineret® and/or Kepivance®. I also authorize the Program, and their agents, to release medical information and related information to each other for purposes of my health care and in order for me to receive Kineret®. A photocopy of this authorization will be as valid as the original.
- I understand that the Kineret® and Kepivance® Patient Assistance Program, HealthBridge may need to work with my social worker or other dialysis center agent to case manage and coordinate care, including drug refills, on my behalf. I hereby grant authority to \_\_\_\_\_ (first/last name), \_\_\_\_\_ (relationship to patient) to act as my representative for the purpose of coordination of therapy in the Kineret® and Kepivance® Patient Assistance Program.

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, which is provided on Parts 1 and 2 of this application, will not be used for any purpose other than for the Program unless:

\*I give written consent, or \* It is required by the government, or \*Biovitrum first removes my name and any other identifying information.

X \_\_\_\_\_ X \_\_\_\_\_  
**Signature of Patient or Legal Representative** **Date**

\_\_\_\_\_  
**Relationship if Other Than Patient**