

Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the "**Healthcare Savings**" tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, \$4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over \$300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.



Rich Sagall, MD
President, NeedyMeds

Clip the card and save



DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.



- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family

- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Patient Assistance Program Application

Please complete and sign this application, then fax it to Kineret® ON TRACK™ at 1-866-549-7219.

Additionally, you may be asked to submit the following:

1 Financial information

- Provide total annual gross household income below
- Please provide supporting financial documents
 - Current federal or state tax return is preferred. If you do not file taxes, alternate documents are acceptable such as current W-2 statement, SSDI/SSI award letter, 1099 form or copy of last 3 pay stubs

If no proof of income is available, the patient or parent/caregiver/authorized representative may complete a notarized income statement or attestation.

2 If the patient is insured, please provide a copy of the patient's current insurance and prescription cards (please make a copy of the front and back)

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: Male Female US Resident: Yes No

Street: _____ Unit: _____ City: _____ State: _____ ZIP Code: _____

Home Phone #: _____ Mobile Phone #: _____

Email: _____ Preferred Contact Method: Phone Email

Best Time to Call: Morning Afternoon Evening Preferred Language: _____

Total annual gross household income \$ _____ (current annual income includes current salary, Social Security, unemployment benefits, pension, IRA)

Include total household number of: Adults (18+), including self _____ Children _____

PARENT/CAREGIVER/AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: _____ First Name: _____ Phone #: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Do you have any form of prescription drug coverage? No Yes

If Yes, please check all that apply:

Employer-furnished or private insurance VA or Military benefits Medicaid State Assistance program for medicines Medicare Part D

Other prescription coverage _____

Plan Name: _____ ID #: _____ Phone #: _____

Have you received a denial letter for Low Income Subsidy application? No Yes

If yes, attach a copy of all appeal/denial letters from your insurance company with the application.

IRA=Individual Retirement Account; SSDI=Social Security Disability Income; SSI=Supplemental Security Income; VA=Veterans Affairs.

CONTINUED ON NEXT PAGE

Patient Assistance Program Application

Patient Last Name: _____ First Name: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Street: _____ Suite: _____ City: _____ State: _____ ZIP Code: _____

NPI #: _____ DEA #: _____ TAX ID #: _____

Medicaid Provider ID #: _____

Office Contact Name: _____ Phone #: _____

Fax #: _____ Email: _____

PRESCRIBER AUTHORIZATION

My signature certifies that the person named on this form is my patient; that the information provided, to the best of my knowledge, is complete and accurate; and that therapy with Kineret is medically necessary. I certify that I have obtained the written authorization of my patient or my patient's parent/caregiver/authorized representative in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Sobi and Kineret ON TRACK patient support program and I understand that the information that I provide on this form will be used by the program for purposes of verifying my patient's insurance coverage and eligibility; coordinating the dispensing of my patient's prescription medicine; and introducing Kineret ON TRACK support services to my patient, including contacting my patient or my patient's parent/caregiver/authorized representative by telephone or mail for these purposes. I authorize Kineret ON TRACK to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Sobi products and that I have not received nor will I receive any benefit from Sobi for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by Kineret ON TRACK.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

SIGN HERE

Prescriber Signature _____ Date _____

PRESCRIPTION INFORMATION

Prescribers in all states must follow applicable law for a valid prescription. For prescribers in states with official prescription form requirements, such as New York, please submit a prescription along with this form in compliance with your state statutes and regulations.

I would like my patient and/or his/her parent/caregiver/authorized representative to receive training on the self-administration of Kineret

Kineret 100 mg/0.67 mL Solution: 28 (twenty-eight) syringes 7 (seven) syringes Other: _____

Directions: Inject: _____ mg subcutaneous every _____ Refills: _____

Known Allergies: _____

Other Medications (please attach current medication list): _____

Stamp Signature Not Allowed

SIGN HERE

Prescriber Signature – Dispense as Written _____ Date _____

OR

Prescriber Signature – Substitution Permitted _____ Date _____

Patient Assistance Program Application

Patient Last Name: _____ First Name: _____ Date of Birth: _____

CONSENT FOR ENROLLMENT INTO THE PATIENT ASSISTANCE PROGRAM

By signing this form I allow my or my child's health plans, other payers, pharmacies, and other healthcare providers ("Providers") to share personal and health information related to the need for Kineret ("Information") by the abovenamed patient ("Patient") with Sobi, Inc., and its contractors, agents and distributors (collectively "Sobi") involved with the Kineret ON TRACK Patient Assistance Program to administer the Sobi Kineret Patient Support program and any related Sobi patient-assistance programs for Patient, and to provide to the US Food and Drug Administration, or other government agencies (to comply with state and federal regulation or coverage eligibility requirements). I understand that some healthcare providers and/or pharmacies may receive payment from Sobi or those acting on behalf of Sobi in exchange for disclosing Patient Information to Sobi and/or for providing Patient with support services, including sending communications to me for purposes of the Kineret ON TRACK program.

I understand that if I do not sign this Authorization or later revoke this Authorization, it will not affect Patient's ability to obtain treatment, payment for treatment, or eligibility for or enrollment in benefits. I understand that I am entitled to keep a copy of this Authorization after I sign it. I understand that this Authorization shall remain in effect for five (5) years from the date I sign this Authorization (or such lesser time period as state law may require), unless I revoke it sooner. I may revoke this Authorization at any time by contacting Kineret ON TRACK in writing at AllCare Plus Pharmacy, 50 Bearfoot Rd, Northborough, MA 01532, Attn: Kineret ON TRACK.

I understand that the revocation will be effective when my Providers are notified of it. If I do revoke the Authorization, my Providers can no longer rely on it to make uses and disclosures of Patient Information as described above, but that will not affect any uses and disclosures already made by my Providers in reliance upon this authorization. I understand that once the Patient Information is shared with Sobi based on this Authorization it may be subject to redisclosure by Sobi, and therefore may no longer be protected by federal privacy regulations, but Sobi plans to use and disclose the Patient Information only as described within this Authorization.

Full name (printed) of patient or parent/caregiver/authorized representative _____

SIGN HERE

Signature of Patient or Parent/
Caregiver/Authorized Representative _____ Date _____

I know that this program may be changed or stopped by Sobi at any time. I know that completing this form does not ensure that I will receive financial assistance or therapy. I understand that Sobi, Inc., does not promise to find ways to pay for the patient's prescription, and I know that I am responsible for the costs of the patient's care. I also certify that the information I have set forth in this application is true, correct, and complete.

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 the product(s) made available under this program may be denied 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 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 also promise to notify Sobi, Inc., should my circumstances change such as the information provided is no longer current (ie, change in insurance coverage or employment status). 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 this form or confirm other medications that the patient is taking.

FAIR CREDIT REPORTING ACT (FCRA) AUTHORIZATION: I understand that I am providing written instructions authorizing Sobi, Inc. and its vendor, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualification for programs administered by Sobi, Inc. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that Sobi, Inc. is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Sobi, Inc. may revise, change, or terminate programs at any time.

Full name (printed) of patient or parent/caregiver/authorized representative _____

SIGN HERE

Signature of Patient or Parent/
Caregiver/Authorized Representative _____ Date _____

CONSENT FOR ENROLLMENT INTO KINERET ON TRACK

By signing below, I am enrolling into Kineret ON TRACK (the "Program"). I authorize Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Sobi, Inc., "Sobi") to provide me and my child with services for which we are eligible under the Program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to enrollment in the copay assistance program if I am eligible.

Full name (printed) of patient or parent/caregiver/authorized representative _____

SIGN HERE

Signature of Patient or Parent/
Caregiver/Authorized Representative _____ Date _____