Adalimumab-aacf

Adalimumab-aacf Enrollment and Prescription Form

Required fields are marked with an asterisk (*).

1. Fax to KabiCare at 1-833-671-1010
2. Upload completed form file to kabicare.trialcard.com
3. Fax to patient's preferred specialty pharmacy
   Questions? Call 1.833.KABICARE (1.833.522.4227)

1 Patient Information - To be completed by a patient or legally authorized person. Please print clearly.

First Name*: _____ Last Name*: _____ D.O.B.*: ___/___/_____ Gender: ☐ M ☐ F

Address*: _____ City*: _____ State*: _____ Zip Code*: _____

Phone Number*: _____ ☐ Home ☐ Cell Email*: _____

Interpretation services needed: ☐ Y ☐ N

Parent/Guardian Name (if applicable): _____ Caregiver Name (if applicable): _____

Language: _____

Best time to call (Monday-Friday): ☐ Anytime ☐ Morning ☐ Afternoon ☐ Evening ☐ Check for permission to leave messages with caregiver

When did you start on treatment?*: ☐ Not yet started ☐ 0-3 months ago ☐ 4-6 months ago ☐ 7-12 months ago ☐ 12+ months ago

Required Patient Authorization and Additional Consents* (all fields must be completed prior to submitting to avoid delay in enrollment)

☐ I have read and agree to the terms and conditions provided, including the Patient Authorization to Share Personal Health Information (Section 1), the Copay Program Terms and Conditions (Section 3), the Bridge to Commercial Coverage (Section 4), the Fair Credit Reporting Act Authorization (Section 5), and/or PAP (Section 7). I understand that agreeing to these terms does not mean I am automatically enrolled in every program.

☐ I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) Consent (Section 2).

Patient or authorized representative signature: _____ Date of signature: ___/___/_____

If authorized representative signature, explain authority to act on behalf of patient: _____

2 Patient's Insurance Information - Provide copies of the front and back of all medical and prescription insurance cards.

Beneficiary/Cardholder Name: _____ Prescription Insurance: _____

Medical Insurance: _____ Rx Group #: _____ Rx ID #: _____

Medical Insurance ID #: _____ Group #: _____ Rx Bin #: _____ Rx PCN #: _____

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Uninsured

▼ FOR HEALTH CARE PROVIDERS ONLY ▼

3

Prescriber's Name (First, Last)*: _____ Site/Clinic Name: _____ Address: _____

Office Phone: _____ Contact Name: _____ City: _____ State: _____ Zip Code: _____

Contact Email: _____ Office Fax*: _____ Tax ID: _____ PTAN: _____

Provider NPI #*: _____ Specialty: ☐ Rheumatology ☐ Gastroenterology ☐ Dermatology ☐ Other

Clinical Information

4

Diagnosis Date: ___/___/_____ Concomitant Medications: _____

Prior Therapies: _____ Drug Allergies: _____

Check all indications that apply:

- ☐ Rheumatoid arthritis
- ☐ Ankylosing spondylitis
- ☐ Juvenile idiopathic arthritis in patients 2 years of age and older
- ☐ Plaque psoriasis
- ☐ Adult psoriatic arthritis
- ☐ Adult uveitis
- ☐ Adult hidradenitis suppurativa
- ☐ Adult Crohn's disease
- ☐ Crohn's disease in pediatric patients 6 years of age and older
- ☐ Adult ulcerative colitis

Primary ICD-10 code: _____

5 Injection Training:

☐ I request supplemental injection training, for this patient. Order valid for up to one year. **Fill out and sign the pharmacy prescription below.**

Pharmacy Prescription - Select medication, fill out and sign corresponding prescription below.

6

Select treatment: Adalimumab-aacf

Patient's preferred specialty pharmacy: _____

Starting therapy: Choose 1 Presentation

☐ AUTOINJECTOR PEN Citrate-Free **40 mg/0.8 mL**

☐ SYRINGE Citrate-Free **40 mg/0.8 mL**

Adult Crohn's Disease, Adult Ulcerative Colitis and Pediatric Crohn's Disease (40 kg (88lbs) and greater)

SIG ☐ 160 mg SC inj. on Day 1 (given in one day or split over two consecutive days); 80 mg SC inj. on Day 15; and 40 mg SC inj. every other week starting on Day 29.
#QS No Refills

Adult Hidradenitis Suppurativa

SIG ☐ 160 mg SC inj. on Day 1 (given in one day or split over two consecutive days); 80 mg SC inj. on Day 15; and 40 mg SC inj. every week starting on Day 29.
#QS No Refills

Rheumatoid Arthritis, Adult Psoriatic Arthritis, Ankylosing Spondylitis, and Juvenile Idiopathic Arthritis (30 kg (66 lbs) and greater)

SIG ☐ 40 mg SC inj. week 1
#QS No Refills

Plaque Psoriasis/Adult Uveitis

SIG ☐ 80 mg SC inj. week 1
#QS No Refills

Ongoing therapy: Choose 1 Presentation

☐ AUTOINJECTOR PEN Citrate-Free **40 mg/0.8 mL**

☐ SYRINGE Citrate-Free **40 mg/0.8 mL**

SIG
- ☐ 40 mg SC inj. every other week
- ☐ 40 mg SC inj. every week†
- ☐ 80 mg SC inj. every other week†

QTY: ☐ 1 month ☐ 3 months

Refills: _____

†Dosage frequency is recommended only for patients not receiving MTX.

PRESCRIBER CERTIFICATION: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed Adalimumab-aacf to the previously identified patient and that I provided the patient with a description of the KabiCare patient support program. I authorize KabiCare to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan (if applicable).

Prescriber's Signature (REQUIRED)*: _____ **Date*:** ____/____/_____

IMPORTANT INFORMATION: By submitting this form you are referring the above patient to Fresenius Kabi's patient support program to determine eligibility and receive support related to a Fresenius Kabi product. Fresenius Kabi, its affiliates, collaborators and agents will use the information collected about you and your patient to provide the patient support and perform research and analytics on a de-identified basis, for management of the program. For more information about the categories of personal information collected by Fresenius Kabi and the purposes for which Fresenius Kabi uses personal information, visit www.fresenius-kabi.com/privacy-statement. Please share this information with your patient.

Please see Important Safety Information on the next page as well as click to see Full Prescribing Information, including **Boxed Warning** for Adalimumab-aacf.

FRESENIUS KABI

Adalimumab-**aacf**

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IMPORTANT SAFETY INFORMATION

SERIOUS INFECTIONS

Patients treated with Adalimumab-aacf are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.

Discontinue Adalimumab-aacf if a patient develops a serious infection or sepsis.

Reported infections include:

- **Active tuberculosis (TB), including reactivation of latent TB. Patients with TB have frequently presented with disseminated or extrapulmonary disease. Test patients for latent TB before Adalimumab-aacf use and during therapy. Initiate treatment for latent TB prior to Adalimumab-aacf use.**
- **Invasive fungal infections, including histoplasmosis, coccidioidomycosis, candidiasis, aspergillosis, blastomycosis, and pneumocystosis. Patients with histoplasmosis or other invasive fungal infections may present with disseminated, rather than localized, disease. Antigen and antibody testing for histoplasmosis may be negative in some patients with active infection. Consider empiric antifungal therapy in patients at risk for invasive fungal infections who develop severe systemic illness.**
- **Bacterial, viral, and other infections due to opportunistic pathogens, including Legionella and Listeria.**

Carefully consider the risks and benefits of treatment with Adalimumab-aacf prior to initiating therapy in patients: 1. with chronic or recurrent infection, 2. who have been exposed to TB, 3. with a history of opportunistic infection, 4. who resided in or traveled in regions where mycoses are endemic, 5. with underlying conditions that may predispose them to infection. Monitor patients closely for the development of signs and symptoms of infection during and after treatment with Adalimumab-aacf, including the possible development of TB in patients who tested negative for latent TB infection prior to initiating therapy.

- Treatment with Adalimumab-aacf should not be initiated in patients with an active infection, including localized infections.
- Patients 65 years of age and older, patients with co-morbid conditions and/or patients taking concomitant immunosuppressants (such as corticosteroids or methotrexate), may be at greater risk of infection.
- Discontinue Adalimumab-aacf if a patient develops a serious infection or sepsis. For a patient who develops a new infection during treatment with Adalimumab-aacf, closely monitor them, perform a prompt and complete diagnostic workup appropriate for an immunocompromised patient, and initiate appropriate antimicrobial therapy.
- Drug interactions with biologic products: A higher rate of serious infections has been observed in RA patients treated with rituximab who received subsequent treatment with a TNF blocker. An increased risk of serious infections has been seen with the combination of TNF blockers with anakinra or abatacept, with no demonstrated added benefit in patients with RA. Concomitant administration of adalimumab products with other biologic DMARDs (e.g., anakinra or abatacept) or other TNF blockers is not recommended based on the possible increased risk for infections and other potential pharmacological interactions.

MALIGNANCY

Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers including adalimumab products. Post-marketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have been reported in patients treated with TNF blockers including adalimumab products. These cases have had a very aggressive disease course and have been fatal. The majority of reported TNF blocker cases have occurred in patients with Crohn's disease or ulcerative colitis and the majority were in adolescent and young adult males. Almost all these patients had received treatment with azathioprine or 6-mercaptopurine concomitantly with a TNF blocker at or prior to diagnosis. It is uncertain whether the occurrence of HSTCL is related to use of a TNF blocker or a TNF blocker in combination with these other immunosuppressants

- Consider the risks and benefits of TNF-blocker treatment prior to initiating or continuing therapy in a patient with known malignancy.
- In clinical trials of some TNF-blockers, including adalimumab products, more cases of malignancies were observed among TNF-blocker-treated patients compared to control patients.
- Non-melanoma skin cancer (NMSC) was reported during clinical trials for adalimumab-treated patients. Examine all patients, particularly those with a history of prolonged immunosuppressant or PUVA therapy, for the presence of NMSC prior to and during treatment with Adalimumab-aacf.
- In adalimumab clinical trials, there was an approximate 3-fold higher rate of lymphoma than expected in the general U.S. population. Patients with chronic inflammatory diseases, particularly those with highly active disease and/or chronic exposure to immunosuppressant therapies, may be at higher risk of lymphoma than the general population, even in the absence of TNF blockers.
- Postmarketing cases of acute and chronic leukemia were reported with TNF blocker use. Approximately half of the postmarketing cases of malignancies in children, adolescents, and young adults receiving TNF blockers were lymphomas; other cases included rare malignancies associated with immunosuppression and malignancies not usually observed in children and adolescents.

HYPERSENSITIVITY

- Anaphylaxis and angioneurotic edema have been reported following administration of adalimumab products. If an anaphylactic or other serious allergic reaction occurs, immediately discontinue administration of Adalimumab-aacf and institute appropriate therapy. In clinical trials of adalimumab, hypersensitivity reactions (e.g., rash, anaphylactoid reaction, fixed drug reaction, non-specified drug reaction, urticaria) have been observed.

HEPATITIS B VIRUS REACTIVATION

- Use of TNF blockers, including Adalimumab-aacf, may increase the risk of reactivation of hepatitis B virus (HBV) in patients who are chronic carriers of this virus. In some instances, HBV reactivation occurring in conjunction with TNF blocker therapy has been fatal.
- Evaluate patients at risk for HBV infection for prior evidence of HBV infection before initiating TNF blocker therapy.
- Exercise caution in prescribing TNF blockers for patients identified as carriers of HBV.
- In patients who develop HBV reactivation, stop Adalimumab-aacf and initiate effective anti-viral therapy with appropriate supportive treatment. The safety of resuming TNF blocker therapy after HBV reactivation is controlled is not known. Therefore, exercise caution when considering resumption of Adalimumab-aacf therapy in this situation and monitor patients closely

NEUROLOGICAL REACTIONS

- Use of TNF blocking agents, including adalimumab products, has been associated with rare cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disease, including multiple sclerosis (MS) and optic neuritis, and peripheral demyelinating disease, including Guillain-Barré syndrome.
- Exercise caution in considering the use of Adalimumab-aacf in patients with preexisting or recent-onset central or peripheral nervous system demyelinating disorders; discontinuation of Adalimumab-aacf should be considered if any of these disorders develop.
- There is a known association between intermediate uveitis and central demyelinating disorders.

HEMATOLOGICAL REACTIONS

- Rare reports of pancytopenia, including aplastic anemia, have been reported with TNF blockers. Medically significant cytopenia has been infrequently reported with adalimumab products.
- Consider stopping Adalimumab-aacf if significant hematologic abnormalities occur.

CONGESTIVE HEART FAILURE

- Worsening or new onset congestive heart failure (CHF) may occur; exercise caution and monitor carefully.

AUTOIMMUNITY

- Treatment with adalimumab products may result in the formation of autoantibodies and, rarely, in development of a lupus-like syndrome. Discontinue treatment if symptoms of a lupus-like syndrome develop.

IMMUNIZATIONS

- Patients on Adalimumab-aacf should not receive live vaccines.
- Pediatric patients, if possible, should be brought up to date with all immunizations before initiating Adalimumab-aacf therapy.
- Adalimumab is actively transferred across the placenta during the third trimester of pregnancy and may affect immune response in the in utero exposed infant. The safety of administering live or live-attenuated vaccines in infants exposed to Adalimumab-aacf *in utero* is unknown. Risks and benefits should be considered prior to vaccinating (live or live-attenuated) exposed infants.

ADVERSE REACTIONS

- The most common adverse reactions in adalimumab clinical trials (>10%) were: infections (e.g. upper respiratory, sinusitis), injection site reactions, headache and rash.

INDICATIONS

- **Rheumatoid Arthritis (RA):** Adalimumab-aacf is indicated, alone or in combination with methotrexate or other non-biologic DMARDs, for reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active rheumatoid arthritis.
- **Juvenile Idiopathic Arthritis (JIA):** Adalimumab-aacf is indicated, alone or in combination with methotrexate, for reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in patients 2 years of age and older.
- **Psoriatic Arthritis (PsA):** Adalimumab-aacf is indicated, alone or in combination with non-biologic DMARDs, for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active psoriatic arthritis.
- **Ankylosing Spondylitis (AS):** Adalimumab-aacf is indicated for reducing signs and symptoms in adult patients with active ankylosing spondylitis.
- **Crohn's Disease (CD):** Adalimumab-aacf is indicated for the treatment of moderately to severely active Crohn's disease in adults and pediatric patients 6 years of age and older.
- **Ulcerative Colitis (UC):** Adalimumab-aacf is indicated for the treatment of moderately to severely active ulcerative colitis in adults.

  Limitations of Use: Effectiveness has not been established in patients who have lost response to or were intolerant to TNF blockers.
- **Plaque Psoriasis (Ps):** Adalimumab-aacf is indicated for the treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate. Adalimumab-aacf should only be administered to patients who will be closely monitored and have regular follow-up visits with a physician.
- **Hidradenitis Suppurativa (HS):** Adalimumab-aacf is indicated for the treatment of moderate to severe hidradenitis suppurativa in adults.
- **Uveitis (UV):** Adalimumab-aacf is indicated for the treatment of non-infectious intermediate, posterior, and panuveitis in adults.

Please click to see Full Prescribing Information, including **Boxed Warning,** for Adalimumab-aacf.

FRESENIUS KABI

ADDITIONAL TERMS AND CONDITIONS FOR ENROLLMENT

Section 1: Patient Authorization for the Use and Disclosure of Protected Health Information

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE HEALTH INFORMATION

By my signature above, I agree to allow my clinicians, pharmacies, specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my personal information, including my protected health information (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder) related to this enrollment and prescription form or my use or potential use of TYENNE to Fresenius Kabi and its agents, authorized representatives, and contractors, including, without limitation, its HUB provider and third parties responsible for the administration of the KabiCare Patient Support Program, as further described below.

Information to Be Disclosed: My protected health information, as well as other state and/or federally protected personal information, including my personal contact and other demographic information, all medical records and financial information, and information relating to my treatment, the coordination of my treatment, and the delivery, packaging, and receipt of certain medication prescribed to me (collectively, my "Information"). Fresenius Kabi may de-identify my Information and such de-identified data will not be subject to this Authorization.

Persons to Whom My Information May Be Disclosed: Fresenius Kabi and the KabiCare Patient Support Program, including any third parties responsible for the administration of the KabiCare Patient Support Program and Fresenius Kabi's HUB provider.

Purposes for Which the Disclosures Are to Be Made: Disclosures of my Information may be made to KabiCare Patient Support Program so that KabiCare Patient Support Program may use and disclose my Information for purposes of:

1) Communicating with my Healthcare Providers about my prescription and medical condition, including to facilitate the order, fulfillment and delivery of my prescription as needed.
2) Establishing my eligibility for benefits from my health plan or other programs;
3) Contacting my insurer on my behalf to determine if I am eligible for health insurance coverage or other funds;
4) Providing appropriate product and reimbursement support;
5) Contacting me regarding case management and/ or educational information or training offered by or through the KabiCare Patient Support Program;
6) Contacting me regarding this Authorization or my use or potential use of my prescriptions and providing me with related communications, including through messages left for me that disclose that I take or may take certain prescription medications;
7) Contacting me to administer the KabiCare Patient Support Programs;
8) Administering, evaluating and improving the KabiCare Patient Support Programs, including performing research and analytics, analyzing the usage patterns and the effectiveness of services and helping to develop new products, services, and programs, and for other general business and administrative purposes; and
9) Disclosing my Information to third parties if required by law.

By signing this Authorization, I acknowledge my understanding that:

- I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will not affect my right to treatment or payment of benefits for health care. However, I understand that if I refuse to sign, I will not be eligible to receive support through the KabiCare Patient Support Program.
- I have the right to revoke this Authorization at any time by calling KabiCare at 1-833-KABICARE (1-833-522-4227) or mailing 2250 Perimeter Park Dr., Suite 300 Morrisville, NC 27560. Revoking this Authorization will prohibit further uses and disclosures of my Information by the KabiCare Patient Support Program, except to the extent those uses and disclosures have been made in reliance on this Authorization and as permitted by applicable law.
- Certain pharmacy providers or other Healthcare Providers may receive remuneration for the use or disclosure of my Information, as permitted by this Authorization.
- Once my Information is released to KabiCare Patient Support Program based on this Authorization, my Information may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. However, I understand that KabiCare Patient Support Program has agreed to use or disclose my Information received only for the purposes described in this Authorization or as required by law.
- This Authorization will remain in effect for a period of two (2) years after I sign it unless a shorter period is required by state law or is revoked by me earlier in writing.
- I am entitled to receive a copy of this signed Authorization.

The patient, or the patient's authorized representative, MUST sign this enrollment and prescription form to participate in the KabiCare Patient Support Program. My signature, signifying my agreement with this Authorization, is provided on page 1 of this enrollment and prescription form, where it states, 'I have read and agree to the Patient Authorization for the Use and Disclosure of Protected Health Information (section 1).' If an authorized representative signs for the patient, please indicate relationship to the patient.

Section 2: Telephone Consumer Protection Act (TCPA) Consent

By checking the second box in the "Required Patient Authorization and Additional Consents" section on page 1 of this enrollment and prescription form, you are agreeing to receive informational and marketing messages, including messages regarding products, health conditions, copay and financial assistance, from KabiCare and its third-party partners, including TrialCard Incorporated. You are providing consent that you can be contacted by phone or text messages through automatic telephone dialing systems under the guidelines of applicable law, such as the Telephone Consumer Protection Act at the phone number you provide. Message & data rates may apply. Message frequency varies. Text the word HELP in response to a text received from KabiCare or its partners for help. You may opt out of receiving text messages by texting the word STOP in response to a text received from KabiCare or its partners. The opt-out keyword STOP needs to be sent from the phone number where you want to stop receiving messages. If you have more than one phone number enrolled, you will need to follow this process with each phone number or contact 1-833-KabiCare (1-833-522-4227) for assistance. If your phone number changes, you should let KabiCare know right away to avoid your messages being sent to your old number. Ideally, you should follow the opt out process described above before you change your phone number. You will also need to let KabiCare know that it is ok to send you text messages to your new number. You may also opt out of communications from KabiCare or its partners entirely at any time by calling 1-833-KabiCare.

KabiCare will not sell or rent your personally identifiable information obtained as part of KabiCare's and its partners' text messaging communications with you and KabiCare does not permit its third-party suppliers, vendors, or contractors to sell any personally identifiable information obtained in the course of KabiCare's business relationship related to its text message communications with you. The information you provide as part of your consent to receive text messages will not be shared with any third parties other than KabiCare's partners and will only be used to document your consent to receive text messages, to send those text messages to you, and to comply with any applicable laws and regulations.

You understand that you are not required to agree to receive any phone calls or text messages as a condition of participation in the KabiCare Patient Support Program, and you may stop receiving text messages at any time by texting the word STOP in response to a text received from KabiCare or its partners.

Section 3: KabiCare Copay Assistance Program TERMS & CONDITIONS

To receive benefits under the Copay Assistance Program, the patient may contact the KabiCare Patient Support Program for current Program Product(s) subject to these Terms and Conditions. By participating in the Copay Assistance Program, patient acknowledges and agrees that he/she is eligible to participate and that he/she understands and agrees to comply with these Terms and Conditions.

- Patient must be prescribed the Program Product for an FDA-approved indication.
- Patient must have commercial (private or non-governmental) health insurance that provides coverage for the cost of the Program Product under a pharmacy or medical benefit plan. Uninsured and cash paying patients may be eligible for other types of support not part of the Copay Assistance Program.
- The Copay Assistance Program is valid for patients who have a valid prescription for a Fresenius Kabi medication and who are not reimbursed for the entire cost of the prescription by their commercial insurance plan. The Copay Assistance Program is not valid for patients enrolled in Medicaid, Medicare (including a Medicare Part D or Medicare Advantage plan, a Medigap plan, or an employer-sponsored health plan or prescription drug benefit program for Medicare-eligible retirees), Veteran Affairs health care programs, Department of Defense health care programs, TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan , or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program, including any state pharmaceutical assistance programs (collectively, "Government Programs"). Patients who move from commercial insurance to Government Programs will no longer be eligible to participate in the Copay Assistance Program and agree to notify the Copay Assistance Program of any such change. If the patient lives in Massachusetts, the Copay Assistance Program expires on the earlier of: (i) the Expiration Date set forth below; (ii) the date an AB-rated generic equivalent becomes available for the Program Product; or (iii) January 31, 2026, absent a change in Massachusetts state law.
- If the patient lives in California, the Copay Assistance Program expires on the earlier of: (i) the Expiration Date set forth below; or (ii) the date an FDA approved therapeutically equivalent for the Program Product or over the counter product with the same active ingredients becomes available.
- Patients must have an out-of-pocket cost for the Program Product prior to the Expiration Date of the Copay Assistance Program.
- The benefit available under the Copay Assistance Program is limited to the amount the patient's private health insurance company indicates that the patient is obligated to pay for up to a per syringe/annual maximum.
- The Program may apply to patient out-of-pocket costs incurred for Program Product subject to per syringe/ annual maximums based on Program Product administration date. After reaching the maximum Copay Assistance Program benefit, the patient will be responsible for all remaining out-of-pocket expenses. The patient or provider may contact the KabiCare Patient Support Program for more information.
- The Patient and participating pharmacy or healthcare professional agree not to seek reimbursement for all, or any part, of the benefit received by the patient through the Copay Assistance Program. Participating patients and pharmacies or health care professionals are responsible for reporting receipt of Copay Assistance Program benefits as may be required by law.
- Patient must be a resident of the United States or the Commonwealth of Puerto Rico. Product must originate and be administered to patient in the United States or the Commonwealth of Puerto Rico.
- All information applicable to the Copay Assistance Program requested on the KabiCare.US site must be provided, and all certifications must be provided.
- No other purchase is necessary.
- The Copay Assistance Program is not insurance.
- It is illegal to sell, purchase, trade, counterfeit, or duplicate, or offer to sell, purchase, trade counterfeit, or duplicate the Copay Assistance Program card. Void if reproduced.
- The Copay Assistance Program is intended to comply with all applicable laws and regulations, including, without limitation, the federal Anti-Kickback Statute, its implementing regulations, and related guidance interpreting the federal Anti-Kickback Statute.
- The Copay Assistance Program is void where prohibited by law, taxed, or restricted. The Copay Assistance Program is not transferable. No substitutions are permitted.
- The Copay Assistance Program benefit has no cash value and cannot be combined with any other Copay Assistance Program, free trial, discount, rebate, prescription savings card, or other offer.
- The full value of the Copay Assistance Program benefit is intended to pass entirely to the patient. No other individual or entity is entitled to receive any discount or other amount in connection with the Copay Assistance Program.
- This offer is not conditioned on any past, present, or future purchase obligation, and the Copay Assistance Program does not obligate the use of any specific product or provider.
- To the extent applicable, this offer will be accepted only at participating pharmacies.
- KabiCare reserves the right to rescind, revoke, terminate, or amend the Copay Assistance Program at any time without notice.
- Data related to patient's receipt of Copay Assistance Program benefits may be collected, analyzed, and shared with KabiCare, for market research and other purposes related to assessing Copay Assistance Programs. Data shared with KabiCare will be aggregated and de-identified, meaning it will be combined with data related to other Copay Assistance Program redemptions and will not identify patient.
- The Terms and Conditions of the Copay Assistance Program are valid for Program Product only, and Fresenius Kabi reserves the right to rescind, revoke, or amend the Program without notice.

Section 4: Bridge to Commercial Coverage – Patient Attestation

KabiCare provides a limited and temporary supply of free product through the KabiCare Commercial Bridge Program ("Commercial Bridge Program") for eligible commercially insured patients when a prior authorization request has been pending with the payer for more than 7 days and when other program eligibility criteria have been satisfied.

The patient and participating providers may not seek reimbursement for any free product provided under the Commercial Bridge Program nor does the Commercial Bridge Program include payment for product administration fees.

By signing above, the patient hereby certifies to the following:

I certify that I am not enrolled in any Federal health care program (such as Medicare, Medicaid, Veteran Affairs health care programs, Department of Defense health care programs, TRICARE, or CHAMPUS). If I am enrolled in the Commercial Bridge Program, I certify that all information provided herein is correct and complete, to the best of my knowledge. I acknowledge that any product provided through the Commercial Bridge Program is provided on a complimentary basis. I certify that I will not submit or cause to be submitted any claims for payment or reimbursement for such products to any third-party payor, including any Federal health care programs. If I am or become in possession of such product, I understand that such product is only for me and I will not give such product to anyone else. I agree that I will not sell, trade, or distribute or otherwise transfer such product.

I understand that if I am enrolled in the Commercial Bridge Program, any future changes to prescription drug coverage, or insurance coverage may affect whether I can continue to participate in the Commercial Bridge Program. I agree to contact KabiCare at 1-833-KABICARE (1-833-522-4227) and tell them about any changes to my prescription drug coverage, or insurance coverage. I understand there is no purchase requirement associated with assistance through by or through the Commercial Bridge Program. I understand that completing this enrollment and prescription form does not guarantee that assistance will be provided.

Section 5: Fair Credit Reporting Act (FCRA) - Patient Authorization

The information I have provided is complete and accurate and will be used to decide if I am eligible to participate in the KabiCare Patient Assistance Program (the "PAP"). I agree that submitting my application is not a guarantee that I am entitled to participate in the PAP or that the PAP is obligated to provide me with any assistance. I understand that the PAP can revise, change, or terminate the program at any time. I authorize my healthcare providers and my health plan or insurers to give my medical and financial information to KabiCare, which administers the PAP on behalf of Fresenius Kabi, the distributor of the medicines, and to Experian, which assesses my income and ability to pay. I authorize KabiCare and its service providers to obtain credit reports about me from one or more credit reporting agencies in order to verify my information and determine my eligibility to participate in the PAP. I authorize KabiCare and Experian to review my medical and financial information and to use it only to determine if I am eligible to participate in the PAP, to operate the PAP, or as otherwise required or permitted by law. I understand and agree that KabiCare and Experian may contact me directly to verify the information I have submitted or to ask for additional information or documentation to process my application.

Section 6: Prescriber Certification and Statement of Medical Necessity

Prescriber Declaration: My signature certifies that the person named on this enrollment and prescription form is my patient, I will be supervising this patient's treatment, and the information that has been provided is complete and accurate to the best of my knowledge.

I also certify that I have made the clinical judgement that any products provided through KabiCare Patient Support Program(s), including KabiCare's Patient Assistance Program (the "PAP") are medically necessary and appropriate for the patient named on this enrollment and prescription form and will be used only by that patient. I will not use any such product or prescribe, provider, furnish, or dispense any portion thereof to any other person or patient. If I am or become in possession of such medications, I will not sell, resell, offer for sale, trade, or barter such products.

In addition, I certify that no claim for payment or reimbursement for any product furnished through KabiCare Patient Support Program(s), including the PAP, will be submitted to any third-party payer, including any Federal health care program (such as Medicare, Medicaid, Veteran Affairs health care programs, Department of Defense health care programs, TRICARE, or CHAMPUS), any other health care benefit plan, payer or patient, or returned for credit.

I further certify that (a) any reimbursement investigation support or assistance provided to patients through KabiCare Patient Support Program is not made in exchange, directly or indirectly, for any past, present, or future recommendation, prescription, purchase, or use of the above therapy or any other product or service for or from anyone and (b) my decision to prescribe product was based solely on my determination of medical necessity as set forth herein. I understand that completing this enrollment and prescription form does not guarantee that assistance will be provided to my patient.

Prescriber Acknowledgement: By submitting this enrollment and prescription form, I acknowledge that I am referring the patient named on this enrollment and prescription form to the KabiCare Patient Support Program(s), including the PAP. By submitting this enrollment and prescription form, I acknowledge and agree that Fresenius Kabi will collect, use, disclose and store personal information about me in accordance with its privacy policy, available at www.fresenius-kabi.com/privacy-statement.

Where required by applicable law, regulation, or other applicable authority, I have obtained appropriate written authorization from the patient ("Legal Permission") permitting me to use and disclose my patients' health, demographic, and other individually identifiable information, including insurance and financial information, to Fresenius Kabi, its affiliates, its program administrator, and their respective agents, authorized representatives, service providers and field reimbursement professionals for the purpose of assessing the patient's insurance coverage and eligibility for participation in the KabiCare Patient Support Program(s), providing the KabiCare Patient Support Program(s), copay assistance, patient assistance, and/or reimbursement support in connection with the patient's treatment with product. I maintain records of such Legal Permission consistent with applicable law.

I appoint KabiCare on my behalf, to convey this prescription to the appropriate dispensing entity, to the extent permitted under applicable state law. 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.

Section 7: Patient Assistance Program - Patient Attestation

I certify that all information provided herein is correct and complete, to the best of my knowledge. To the extent I receive any free product through programs offered by or through the KabiCare Patient Support Programs, including the KabiCare Patient Assistance Program ("PAP"), I acknowledge that such product is provided on a complimentary basis. I certify that I will not submit or cause to be submitted any claims for payment or reimbursement for such products to any third-party payor, including any Federal health care programs (such as Medicare, Medicaid, Veteran Affairs health care programs, Department of Defense health care programs, TRICARE, or CHAMPUS). If I am or become in possession of such product, I understand that such product is only for me, and I will not give such product to anyone else. I agree that I will not sell, resell, offer for sale, trade, barter, distribute or otherwise transfer such product. I understand that if I am enrolled in a Medicare Part D Plan (including a Medicare Advantage Prescription Drug Plan) or other Federal health care program, I may not apply any assistance I receive to my "True Out of Pocket" ("TrOOP") expenditures, and that it is my responsibility to notify such Federal health care program(s) of any assistance I may receive, including my enrollment in the PAP. I understand that if I am enrolled in the PAP, any future changes to my income, prescription drug coverage, or insurance coverage may affect whether I can continue to participate in the PAP. I agree to contact KabiCare at 1-833-KABICARE (1-833-522-4227) and inform them about any changes to my income, prescription drug coverage, or insurance coverage. I understand there is no purchase requirement associated with assistance through by or through any KabiCare Patient Support Program(s), including the PAP.

I understand that Fresenius Kabi reserves the right at any time and without notice to me to modify and/or discontinue any or all support offered by or through KabiCare Patient Support Programs, including modification of eligibility criteria, covered medications and immediate termination of assistance provided through the PAP.

FRESENIUS KABI