1-866-Kineret (1-866-546-3738)

SAFETY NET® Foundation
for Kineret™ (anakinra)

Instructions

The SAFETY NET® Foundation for Kineret™ provides temporary product assistance to financially needy patients who meet predetermined eligibility criteria. To receive free product, the prescriber and patient must complete a SAFETY NET® Foundation application.

To obtain an application or to initiate the application process, please call Kineret™ Reimbursement Services at 1-866-Kineret (1-866-546-3738). Reimbursement counselors are available Monday through Friday, 8:00 AM to 8:00 PM ET.

Faxed copies of applications are accepted. Eligibility determinations are made within 5 business days of receipt of complete documentation. Complete documentation includes:

1. Patient Portion
The patient must complete *Part 1: Patient Portion* of the application. General demographic information, detailed insurance, and financial information must be provided. The patient is required to sign the Application Declaration.

2. Physician Portion
The patient's provider must complete *Part 2: Physician Portion* of the application. General provider information and patient medical necessity information is required. The provider is required to sign the Physician Declaration.

3. Prescriptions
As requested in Part 2 of the application, a prescription for Kineret™ is required. If the patient does not have a Kineret Hands On Starter Kit™ and would like one, a prescription for SimpleJect™ is also required.

Additional Application Materials
The application materials also include a *Patient Authorization to Disclose Protected Health Insurance Information* form. By signing this form, the patient provides authorization for their provider to disclose the information requested in Part 2 of the application. This form should be completed by the patient and given to the provider for their records.

The SAFETY NET® Foundation reserves the right to approve or deny any SAFETY NET® Foundation application or to modify or discontinue the program with respect to any patient or provider, or in its entirety, at any time.

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Patient Authorization to Disclose Protected Health Information

To the Patient: If you want the SAFETY NET® program to access your eligibility for participation in the SAFETY NET® Foundation, you must expressly authorize your physician to disclose to us the information about you requested in Part 2 of the Application. This authorization must be in writing and signed separately from the Application. Please complete this authorization form, date and sign it, and give it to your physician.

Authorization Statement

I, ______________________________ (print patient's name), hereby authorize my physician, ______________________________ (print physician's name), to disclose to the SAFETY NET® Foundation, Lash Group, and Amgen, demographic information about me (for example, my name, social security number, and date of birth), as well as information concerning my medical condition which indicates that use of Kineret™ is medically necessary.

I understand that I may revoke this authorization at any time, except to the extent that my physician has taken action in reliance on it, by mailing or faxing a written request to my physician to revoke the authorization. I also understand that, once disclosed, this information may no longer be subject to federal regulations with respect to the confidentiality of medical information and thus may be subject to re-disclosure if permitted by applicable state law.

This authorization expires the latter part of 1 year after the date it is signed or 1 year after the last date I receive product under the program.

Required Signature

______________________________ Signature of patient or legal representative

__________ Date

If signed by patient's legal representative, complete the following:

Print name of legal representative: ______________________________

Describe representative's authority to act for patient: ______________________________

Important: Once you have completed and signed this authorization form, please give it to your physician. Do not send it to the SAFETY NET® Foundation.

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Part 1 of 2: Patient Portion

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 below. The application process can be initiated based on receipt of a faxed application and prescription.

SAFETY NET® Program for Kineret™, P.O. Box 221858, Charlotte, NC 28222-1858

Toll-free Telephone: 1-866-Kineret (1-866-546-3738) Toll-free Fax: 1-866-203-4926

Patient Name: ______________________ SS#: ______________________

Date of Birth: ______________ Patient Language: ☐ English ☐ Spanish ☐ Other __________

Mailing Address: ______________________

Street Address (include Apt #): ______________________

City, State, Zip: ______________________

Daytime number: (____) __________ Evening number: (____) __________ Other: (____) __________

Best time to call (between 8:00 AM–8:00 PM ET): ________ Best number to call during this time: ☐ Day ☐ Evening ☐ Other

COVERAGE AND INSURANCE

Do you have insurance coverage? ☐ Yes ☐ No (If yes, complete the table below, including primary and secondary insurance policies.)

	Medicare	Medicaid	Commercial	Other
Insurance company name				
Policy number				
Group number				
Telephone number				
Policyholder's name				
Policyholder's date of birth				
Prescription benefits?				

Have you ever applied for Medicaid? ☐ Yes ☐ No If Yes, date of application: ______________

Are you eligible? ☐ Yes ☐ No ☐ Pending If not eligible, reason for denial: ______________

FINANCIAL INFORMATION

Current annual household gross income $______________

Number of household members dependent on income stated above (including applicant) ______________

Please indicate all sources of income by checking the appropriate box(es) below:

☐ Social Security (SS) Benefits ☐ Supplemental Security Income (SSI) ☐ Social Security Disability Income (SSDI)

☐ Job ☐ Family ☐ Other (Please explain):

APPLICATION DECLARATION

My doctor has prescribed Kineret™ for me and I would like to receive the drug free of charge through the SAFETY NET® Foundation (the "Foundation"). 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 Foundation, Lash Group and Amgen.

I understand that, in order to determine my eligibility to participate in the Foundation, the Foundation needs information about my medical diagnosis, my family income, and my health insurance. I agree to permit information about me to be given to the Foundation, Lash Group, and Amgen 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 Foundation. I further authorize the Foundation to provide Amgen with information concerning any assistance provided to me by the Foundation.

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 Foundation 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.

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 Foundation unless:

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

Print name of patient or legal representative ______________________ Date __________

Signature of patient or legal representative ______________________ Date __________

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Part 2 of 2: Physician Portion

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

SAFETY NET® Foundation for Kineret™, P.O. Box 221858, Charlotte, NC 28222-1858

Toll-free Telephone: 1-866-Kineret   Toll-free Fax: 1-866-203-4926

PATIENT INFORMATION

Patient Name: ____________________ SS#: ____/____/____ Date of Birth: ____/____/____

PHYSICIAN INFORMATION

Physician Name: ____________________ State License #: ____________________

Facility Name: ____________________

Correspondence Address: ____________________

City: ____________________ State: __________ Zip: __________

Telephone: ____________________ Fax: ____________________

Office Contact Name and Extension: ____________________ (eg, nurse or other representative we should contact regarding this patient)

PRODUCT DISTRIBUTION

Patients who qualify for assistance will receive free product shipped to the address indicated in the "Patient Information" section of this application. If you and the patient would prefer for the medication to be shipped to an alternate address, please provide that address below. (Please note that medication cannot be shipped to a post office box.)

Contact Name: ____________________

Street Address (including suite number): ____________________

City: ____________________ State: __________ Zip: __________

Telephone: ____________________ Fax: ____________________

MEDICAL NECESSITY INFORMATION

Patient's Diagnosis (include ICD-9-CM code): ____________________

PRESCRIPTION INFORMATION

Please attach two prescriptions to this application: a prescription for Kineret™ and a prescription for one SimpleJect™, if needed. Medication will be dispensed in a 2-month supply; therefore, prescriptions for Kineret™ must be written for at least a 56-day supply. Prescriptions may be written for up to a 1-year supply.

PHYSICIAN DECLARATION

I represent that the information contained in this completed application (Parts 1 and 2) is complete and accurate to the best of my knowledge and agree to notify the SAFETY NET® Foundation of any changes of which I become aware that could affect the patient's eligibility status.

Physician's Signature: ____________________ Date: __________

Print Physician's Name: ____________________ Date: __________

As part of your patient's eligibility, you will be asked to periodically verify continued use of Kineret™ and to re-submit a current prescription, as appropriate.