Doptelet® (avatrombopag) tablets

Doptelet® (avatrombopag) connect™

Doptelet Patient Assistance Program Application

Please complete and sign this application, then fax it to Doptelet Connect at 1-855-686-8729.
Additionally, you may be asked to submit the following:

1. **Proof of income**
   (Examples: 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'S PARENT/CAREGIVER MAY SUBMIT A NOTARIZED LETTER DETAILING HIS/HER INCOME

2. **A copy of the patient's current insurance and prescription cards (please make a copy of the front and back)**
   - **Include total household number of: Adults (18+), including self _________ Children _________**

PATIENT INFORMATION

Last Name: ____________________________ First Name: ____________________________ Middle Initial: _____ Date of Birth: _______________

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: ◯ English ◯ Spanish ◯ Other: _________________________

US Resident: ◯ Yes ◯ No

CAREGIVER INFORMATION

Last Name: ____ First Name: ____ Middle Initial: ___________

Relationship to Patient: ____

INSURANCE INFORMATION

Do you have any form of prescription drug coverage? ◯ No ◯ Yes Plan Name: _______________________________ ID #: _________________

If Yes, please check all that apply:

◯ Employer-furnished or private insurance

◯ VA or Military benefits

◯ Medicaid State Assistance program for medicines

◯ Medicare D

◯ Other prescription coverage: ____

Have you received a denial letter for Low Income Subsidy application ◯ Yes* ◯ No
*If Yes, attach a copy of all appeal/denial letters from your insurance company to the application.

SSDI=Social Security Disability Income; SSI=Supplemental Security Income; VA=Veterans Affairs.

CONTINUED ON NEXT PAGE

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

PRESCRIBER INFORMATION

Last Name: ____________ First Name: ____________ Office/Institution Name: ____________

Street: ____________ Suite: ______ City: ____________ State: ______ ZIP Code: ________

NPI #: ____________ DEA #: ____________ Tax ID #: ____________

Medical Provider ID #: ____________

Office Contact Name: ____________ Phone #: ____________

Fax #: ____________ Email: ____________

SIGN HERE Prescriber Signature ____________ Date ________

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 Doptelet is medically necessary. I certify that I have obtained the written authorization of my patient in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Sobi and the Doptelet Connect 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 Doptelet Connect support services to my patient, including contacting my patient by telephone or mail for these purposes. I authorize Doptelet Connect to transmit the above prescription to the appropriate 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 Doptelet Connect.

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

CLINICAL INFORMATION Attach any required clinical notes.

◯ **Chronic immune thrombocytopenia (ITP) in adult patients**

ITP diagnosis code (ICD-10): D69.3

Other: ____________

Prior treatment: ____________

____

◯ **Thrombocytopenia (TCP) in adult patients with chronic liver disease (CLD)**

CLD diagnosis code (ICD-10): ____________

TCP diagnosis code (ICD-10): ____________

Known procedure date (MM/DD/YYYY): ____________

Begin taking (MM/DD/YYYY): ____________

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.

◯ Doptelet® (avatrombopag) 20-mg tablets 10 ct (NDC # 71369-0020-10)

◯ Doptelet® (avatrombopag) 20-mg tablets 15 ct (NDC # 71369-0020-15)

◯ Doptelet® (avatrombopag) 20-mg tablets 30 ct (NDC # 71369-0020-30)

Directions: ____________

____

Quantity/day: ____________ Patient platelet count: ____________ ◯ Refill(s): ____________

Allergies: ____________ Other medications: ____________

Stamp Signature Not Allowed

SIGN HERE Prescriber Signature ____________ Date ________

Dispense as written

OR

Prescriber Signature ____________ Date ________

Substitution Permitted

ICD-10=*International Classification of Diseases, Tenth Edition*; NDC=National Drug Code.

CONTINUED ON NEXT PAGE

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Doptelet Patient Assistance Program Application

Patient Last Name: ______________________ First Name: ______________________ Date of Birth: ____________

CONSENT FOR ENROLLMENT IN THE PATIENT ASSISTANCE PROGRAM

By signing this form I allow my health plans, other payers, pharmacies, and other healthcare providers ("Providers") to share personal and health information related to the need for Doptelet ("Information") by the above named patient ("Patient") with Sobi, Inc., and its contractors, agents and distributors (collectively "Sobi") involved with the Doptelet Connect Patient Assistance Program to administer the Sobi Doptelet 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 Doptelet Connect program.

I understand that if I do not sign this Authorization or later revoke this Authorization, it will not affect my 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 Doptelet Connect in writing at Doptelet Connect, PO Box 5490, Louisville, KY 40255-5490.

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: ____

SIGN HERE Signature of Patient ____________________________________ 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 my prescription, and I know that I am responsible for the costs of my 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 or if the information that I 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 I am 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 myself 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: ____

SIGN HERE Signature of Patient ____________________________________ Date ____________

CONSENT FOR ENROLLMENT INTO DOPTELET CONNECT

By signing below, I am enrolling into Doptelet Connect (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 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: ____

SIGN HERE Signature of Patient ____________________________________ Date ____________

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