Doptelet® connect

DOPTELET PATIENT/AUTHORIZED REPRESENTATIVE CONSENT FORM

Doptelet Connect™ offers access and reimbursement support to help patients access Doptelet® (avatrombopag). Doptelet Connect provides information regarding patient healthcare coverage options and financial assistance information that may be available to help patients with financial needs.

In order for the patient to get full support services, consent/authorization must be obtained.
Please complete this form legibly and sign it. All completed forms should be faxed to 1-855-686-8729.

1 PATIENT AND AUTHORIZED REPRESENTATIVE INFORMATION

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 Gender: ◯ Male ◯ Female

Preferred Language: ◯ English ◯ Spanish ◯ Other: _____ US Resident: ◯ Yes ◯ No

AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: _____ First Name: _____ Relationship to Patient: _____

Phone #: _____ Email: _____

2 PRESCRIBER INFORMATION

Last Name: _____ First Name: _____ Office/Institution Name: _____

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

NPI #: _____ Medicaid Provider ID #: _____ Tax ID #: _____

Office Contact Name: _____ Phone #: _____

Fax #: _____ Email: _____

3 PATIENT AUTHORIZATION STATEMENT

My signature on this consent form authorizes my doctor(s), healthcare providers, health plan or payer, and my pharmacy to disclose to Sobi, Inc. ("Company") and its third party suppliers, vendors, and other service providers supporting Doptelet Connect (collectively, the "Service Providers") information about me (for example, my name, social security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Protected Health Information and/or Personally Identifiable Information"). This information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my information or providing support services which may be considered marketing pursuant to this Authorization. I understand that Doptelet Connect and other Service Providers may be compensated by Company. The Service Providers will use and give out my information to (i) assist in my enrollment in Doptelet Connect and to contact me and/or the person legally authorized to sign on my behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational material and other information materials related to the Doptelet Connect offerings; (iii) verify, investigate, assist with, and coordinate my coverage for Doptelet with my payer; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance programs, if necessary and applicable; and (vi) assist with analyses of the efficiencies and performance of services provided by Service Providers. As part of my enrollment in Doptelet Connect, I agree to my enrollment in the Doptelet Copay Assistance Program if I am eligible. In some instances, the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws. This authorization will last for three (3) years from the date of my signature or until I am no longer receiving Doptelet or enrolled in Doptelet Connect, whichever is later, unless a shorter period is mandated by state law. I understand that I do not have to sign this authorization, but if I do not, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of Doptelet Connect. My choice as to whether to sign this form will not change the way my doctors, healthcare providers, or payers treat me. If I no longer wish to participate in Doptelet Connect, I shall inform my healthcare providers and/or the administrators of Doptelet Connect in writing to Doptelet Connect at 150 Hilton Drive, Jeffersonville, IN 47130, that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of Doptelet Connect. Cancellation of this authorization will be valid when received by the administrators of Doptelet Connect. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I know I have a right to see or request a copy of the information my healthcare providers or payers have given to the Service Providers. If I am being evaluated for the Doptelet patient assistance program ("PAP"), I agree to allow Company and Service Providers to use my demographic information, including, but not limited to, social security number, date of birth, name, and/or address as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed in reviewing eligibility under the PAP. Company and Service Providers reserve the right to ask for additional documents and information at any time. I agree to notify my healthcare providers if I become aware in the future of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residing status. If I receive services offered under Doptelet Connect, I agree to allow Company and Service Providers to contact me via email or cell phone using the contact information provided in this consent form.

SIGN HERE Signature of Patient _____ Date _____

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