Enrollment Form for AURYXIA® (ferric citrate)

Akebia cares℠

Phone 855-686-8601 | Fax 866-310-7424 | Email support@akebiacares.com

Akebia® THERAPEUTICS

☐ **BENEFITS VERIFICATION ONLY**
Complete sections A, B, C, D, E, and F.
Healthcare Professional Signature and Both Patient Signatures Required.

☐ **BENEFITS VERIFICATION AND PATIENT ASSISTANCE PROGRAM**
Complete **all** sections.
Prescriber Signature and Both Patient Signatures Required.

☐ **I already know my patient's out-of-pocket cost and am requesting Patient Assistance Program evaluation.**

A PATIENT INFORMATION

LEGAL NAME (First, Middle, Last):	SUFFIX:	GENDER:	DATE OF BIRTH (MM/DD/YYYY):
		☐ MALE ☐ FEMALE	/ /

PRIMARY PHONE:	EMAIL ADDRESS:
( ) - ☐ CELL ☐ HOME ☐ OTHER	

STREET ADDRESS (NO PO BOX):	APT#:	CITY:	STATE:	ZIP:

PATIENT REPRESENTATIVE NAME (IF APPLICABLE):	RELATIONSHIP TO PATIENT:	IS THE PATIENT ON DIALYSIS?
		☐ YES ☐ NO

PREFERRED PHARMACY (HELPFUL TO DETERMINE EXACT COST SHARE):

B PRESCRIPTION DRUG INSURANCE INFORMATION Send A Copy (Front and Back) Of The Patient's Prescription Insurance Card

PRIMARY INSURANCE:	RX PCN#:	RX BIN#:	RX GROUP#:

CARDHOLDER NAME:	MEMBER ID#:	
		☐ PATIENT DOES NOT HAVE INSURANCE

C PATIENT HIPAA AUTHORIZATION TO USE AND SHARE PROTECTED HEALTH INFORMATION (REQUIRED)

☐ **PLEASE SEND AN EMAIL TO MY PATIENT TO COLLECT ELECTRONIC SIGNATURES**

By signing below, I authorize my healthcare professionals, including my physicians and pharmacies ("My Providers"), and my health insurance plan ("My Plan") to use and share my identifiable medical information (such as information about my diagnosis and treatment) and my identifiable insurance information (collectively, "My Information") with Akebia Therapeutics, Inc., and its subsidiaries (including Keryx Biopharmaceuticals, Inc.), affiliates, representatives, agents, and contractors ("Akebia") so that Akebia can provide me with information, assistance, and support through AkebiaCares ("Patient Support") as described below; administer and analyze the effectiveness of AkebiaCares; ask if I am interested in participating in market research; carry out other business purposes related to AURYXIA®; and comply with law. I understand and agree that my pharmacies may receive payment from Akebia in exchange for sharing My Information with Akebia. Once My Information has been shared with Akebia, federal privacy laws may no longer protect the information. However, Akebia agrees to protect My Information by using and disclosing it only for purposes described in this authorization. I may refuse to sign this authorization and doing so will not affect my treatment, insurance coverage, or eligibility for benefits for which I am otherwise entitled. However, refusing to sign this authorization means that I cannot participate in AkebiaCares. I may cancel or revoke this authorization at any time by mailing a letter to AkebiaCares, P.O. Box 5490, Louisville, KY 40255 or by sending an email to support@akebiacares.com. If I revoke this authorization, My Providers and My Plan will stop using and sharing My Information, but my revocation will not affect uses and disclosures of My Information made in reliance upon this authorization prior to my revocation. This authorization expires ten (10) years from the date signed below, or earlier if required by state or local law, unless I revoke it before then. I will receive a copy of my signed authorization.

PRINT PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE NAME*:	RELATIONSHIP TO PATIENT:

SIGNATURE OF PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE*:	DATE: / /

D PATIENT CONSENT TO PARTICIPATE IN AkebiaCares (REQUIRED)

checking #########

AkebiaCares is a program administered by Akebia that provides Patient Support to eligible patients who have been prescribed AURYXIA®. Patient Support includes: (1) providing reimbursement and financial support (such as investigating insurance coverage, confirming out-of-pocket costs, and reviewing eligibility for financial assistance); (2) working with patients and their healthcare professionals to fill their prescriptions; and (3) providing patients with disease and medication-related educational resources and communications. By signing below, I confirm that I would like to enroll in AkebiaCares and that I want Akebia to provide me with Patient Support.

If I am applying for financial assistance, I also agree that Akebia can use the information provided on this form or otherwise provided by me directly or through My Providers (including my Social Security number, household information, and household income) to obtain credit reports about me from credit reporting agencies in order to verify the information, estimate my income, and determine my eligibility for financial assistance. Regardless of whether a credit report is obtained, Akebia has the right to require written proof of income (such as a Form 1040, Form W-2, or other documentation) from me in connection with a financial eligibility determination.

AkebiaCares is an optional program. I may withdraw from AkebiaCares at any time by mailing a letter to AkebiaCares, P.O. Box 5490, Louisville, KY 40255 or by sending an email to support@akebiacares.com. Akebia may use My Information and share it with My Providers or My Plan in connection with providing Patient Support and for the other purposes described in the authorization above. For example, Akebia may communicate with me (such as by mail, phone, or email) or my representative, use My Information to tailor AkebiaCares-related communications to my needs, and share information with My Providers about dispensing AURYXIA® to me. Akebia may de-identify My Information and use the de-identified information for Akebia's business purposes. If my insurance information changes at any time while I am participating in AkebiaCares, I will notify AkebiaCares as soon as possible.

PRINT PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE NAME*:	RELATIONSHIP TO PATIENT:

SIGNATURE OF PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE*:	DATE: / /

***The authorized patient representative may not be the patient's healthcare professional.**

• TURN OVER •