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)

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 •

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Akebia® THERAPEUTICS

PATIENT NAME (First, Middle, Last):	DATE OF BIRTH (MM/DD/YYYY):
	/ /

E PRESCRIBER INFORMATION

PRESCRIBER NAME:	PRESCRIBER PRACTICE NAME:	PRESCRIBER NPI:

PRACTICE ADDRESS:	STE#:	CITY:	STATE:	ZIP:

DIALYSIS FACILITY NAME (IF APPLICABLE):

DIALYSIS FACILITY ADDRESS (IF APPLICABLE):	STE#:	CITY:	STATE:	ZIP:

CONTACT PERSON:	CONTACT LOCATION:	TITLE:
	☐ PRESCRIBER ☐ DIALYSIS FACILITY	☐ RD ☐ RN ☐ PA ☐ SW ☐ NP ☐ LPN ☐ MA

CONTACT PHONE:	CONTACT FAX:	CONTACT EMAIL:
( ) - ☐ CELL ☐ OFFICE	( ) -	

F HEALTHCARE PROFESSIONAL SIGNATURE FOR BENEFITS VERIFICATION SERVICES (REQUIRED)

I attest that I am involved in the care and treatment of the patient and that I am making the below certifications and acknowledgements in consultation with and on behalf of the patient's prescriber. By signing below, I certify and acknowledge that (1) AURYXIA® is medically necessary and is in the best interests of the patient identified on this form; (2) the information in this form is accurate and complete to the best of my knowledge; (3) I am submitting this form to AkebiaCares to enroll the patient in AkebiaCares; (4) I am aware that the submission of this form to AkebiaCares does not guarantee that the patient will be eligible for AkebiaCares; (5) services provided by or on behalf of Akebia and/or AkebiaCares do not include the provision of treatment or medical advice or replace the treatment and care provided by the patient's prescriber; (6) any service provided by or on behalf of Akebia and/or AkebiaCares is not made in exchange for any express or implied agreement or understanding that the patient's prescriber will recommend, prescribe, or use AURYXIA® or any other Akebia product, and any decision to prescribe AURYXIA® was, and in the future will be, based solely on the prescriber's determination of medical necessity; and (7) I have obtained the required authorizations from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to Akebia and AkebiaCares.

PRINT HEALTHCARE PROFESSIONAL NAME:	TITLE:

HEALTHCARE PROFESSIONAL SIGNATURE:	DATE: / /

G INCOME INFORMATION* (REQUIRED FOR PATIENT ASSISTANCE PROGRAM EVALUATION)

LAST 4 DIGITS OF SSN:	NO. OF PEOPLE IN HOUSEHOLD:	TOTAL ANNUAL HOUSEHOLD INCOME (BEFORE TAXES):
		$ (Include All Income: Wages, Pension, Social Security, Disability, Alimony, Interest/Dividends, Rental Property Income, etc)

*Akebia has the right to require written proof of income (such as a Form 1040, Form W-2, or other documentation) from patients in connection with a financial eligibility determination should the Automated Income Verification process produce invalid or no results.

H PRESCRIPTION INFORMATION (To ePrescribe, please select PharmaCord, using NABP/NCPDP (1836191) or NPI (1699202838)

PATIENT NAME (First, Middle, Last):	DATE OF BIRTH (MM/DD/YYYY):
	/ /

SELECT MEDICATION:	SHIP TO:	MEDICATION ALLERGIES? (IF YES, LIST ALL DRUG ALLERGIES):
☐ AURYXIA® (ferric citrate)	☐ PATIENT ☐ FACILITY (IF PERMITTED) ☐ PRESCRIBER	☐ YES ☐ NO

☐ PATIENT ASSISTANCE PROGRAM	SIG/DIRECTIONS:	QUANTITY: 30-DAY SUPPLY	NO. OF REFILLS:
☐ STARTER OR BRIDGE THERAPY	SIG/DIRECTIONS:	QUANTITY: 30-DAY SUPPLY	NO. OF REFILLS:

CURRENT MEDICATIONS (PLEASE LIST OR ATTACH):

I PRESCRIBER SIGNATURE FOR PATIENT ASSISTANCE PROGRAM OR *STARTER/BRIDGE THERAPY* (REQUIRED)

I attest I am responsible for the care and treatment of the patient and that I am making the certifications and acknowledgments outlined in Section F.

PRINT PRESCRIBER NAME:	PRESCRIBER STATE LICENSE NUMBER:

PRESCRIBER SIGNATURE:	DATE: / /

Please see accompanying full Prescribing Information.

