KERYX PATIENT PLUS ENROLLMENT FORM FOR AURYXIA®

Keryx Patient Plus: Phone (855) 686-8601 | Fax (866) 310-7424 | Email KPP@keryx.com

KERYX IS NOW Akebia® THERAPEUTICS

BENEFITS VERIFICATION

☐ Complete sections A, B, C, D, and E. **Both Patient Signatures are Required.**

PATIENT ASSISTANCE PROGRAM

☐ Complete all sections. **Prescriber Signature and Both Patient Signatures are Required.**

A PATIENT INFORMATION

NAME (First, Middle, Last):	SUFFIX:	GENDER:
		○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY):	SSN:	PRIMARY PHONE:
/ /	- -	- -

STREET ADDRESS:	APT#:	CITY:	STATE:	ZIP:

PATIENT REPRESENTATIVE NAME:	RELATIONSHIP TO PATIENT:

B PRESCRIPTION DRUG INSURANCE INFORMATION | Please 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 PRESCRIBER INFORMATION

PRESCRIBER NAME:	PRESCRIBER NPI:	CONTACT PERSON:	TITLE:
			○ RD ○ RN ○ PA ○ SW ○ NP ○ MA

CONTACT PHONE:	CONTACT EMAIL:	CONTACT FAX:	PREFERRED CONTACT METHOD:
- -		- -	○ EMAIL ○ PHONE

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

DIALYSIS FACILITY NAME (If Applicable):

ADDRESS OF DIALYSIS FACILITY (If Applicable):	STE#:	CITY:	STATE:	ZIP:

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

By signing below, I authorize my healthcare providers, 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 Keryx Biopharmaceuticals, Inc., a wholly owned subsidiary of Akebia Therapeutics, Inc., and its affiliates, representatives, agents, and contractors ("Akebia") so that Akebia can provide me with information, assistance, and support through Keryx Patient Plus ("Patient Support") as described below; administer and analyze the effectiveness of Keryx Patient Plus; 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 Keryx Patient Plus. I may cancel or revoke this authorization at any time by mailing a letter to Keryx Patient Plus, P.O. Box 877, Somerville, NJ 08876 or by sending an email to KPP@keryx.com. If I revoke this authorization, My Providers 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:**
	/ /

E PATIENT CONSENT TO PARTICIPATE IN KERYX PATIENT PLUS (REQUIRED)

Keryx Patient Plus 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 providers to fill their prescriptions; and (3) providing patients with disease and medication-related educational resources and communications. By signing below, I confirm I would like to enroll in Keryx Patient Plus, and I authorize Akebia to provide me with Patient Support. Keryx Patient Plus is an optional program. I may withdraw from Keryx Patient Plus at any time by mailing a letter to Keryx Patient Plus, P.O. Box 877, Somerville, NJ 08876 or by sending an email to KPP@keryx.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 Keryx Patient Plus-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 Keryx Patient Plus, I will notify Keryx Patient Plus as soon as possible.

PRINT PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE NAME:	RELATIONSHIP TO PATIENT:
SIGNATURE OF PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE:	**DATE:**
	/ /

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FOR PATIENT ASSISTANCE PROGRAM EVALUATION ONLY

F PRESCRIPTION INFORMATION

SELECT MEDICATION:	SHIP TO:	SIG/DIRECTIONS:	QUANTITY:	NO. OF REFILLS:
☐ AURYXIA® (ferric citrate)	☐ PATIENT ☐ FACILITY ☐ PRESCRIBING HCP			

G PATIENT FINANCIAL INFORMATION FOR PATIENT ASSISTANCE PROGRAM

NO. OF PEOPLE IN HOUSEHOLD:	TOTAL HOUSEHOLD INCOME (Before Taxes)
	$ ☐ MONTHLY ☐ ANNUAL (Include All Income: Wages, Pension, Social Security, Disability, Alimony, Interest/Dividends, Rental Property Income, etc)

IS THE PATIENT A US CITIZEN?	IF NO, IS PATIENT A PERMANENT US RESIDENT?	PROOF OF INCOME:
☐ YES ☐ NO	☐ YES ☐ NO	☐ 1040 ☐ W-2 ☐ SSA BENEFIT STATEMENT ☐ PAY STUB (Within Last 3 Months)

H PRESCRIBER SIGNATURE (REQUIRED)

By signing below, I certify and acknowledge that (1) AURYXIA® is medically necessary and is in the best interests of the patient identified above; (2) the information in this form is accurate and complete to the best of my knowledge; (3) I am submitting this form to Keryx Patient Plus to enroll the patient in Keryx Patient Plus; (4) I am aware that the submission of this form to Keryx Patient Plus does not guarantee that the patient will be eligible for Keryx Patient Plus; (5) services provided by or on behalf of Akebia and/or Keryx Patient Plus do not include the provision of treatment or medical advice or replace the treatment and care provided by me as the patient's healthcare provider; (6) any service provided by or on behalf of Akebia and/or Keryx Patient Plus is not made in exchange for any express or implied agreement or understanding that I 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 my 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 Keryx Patient Plus.

PRINT PRESCRIBER NAME:	PRESCRIBER STATE LICENSE NUMBER:
PRESCRIBER SIGNATURE:	**DATE:**
	/ /

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