KERYX PATIENT PLUS

Phone: (855) 686-8601 **Fax:** (866) 310-7424
Email: KPP@keryx.com

Benefits Verification ☐ Complete section A, B, C, and D | **Patient Assistance Program** ☐ Complete section A, B, C, E, F, and G

A) Patient Information *(Mandatory for both)*

First Name: | Middle: | Last Name: | Suffix:

Date of Birth: | SSN: | Gender: ☐Male ☐Female

Street Address: | Apt.#:

City : | State: | ZIP Code: | Primary Phone:

Patient Representative: | Relation:

B) Facility & Prescriber Information *(Mandatory for both)*

Contact Person: | Title: ☐RD ☐SW ☐RN ☐NP ☐PA ☐MA | Preferred Contact Method: ☐Phone ☐Email

Phone: | Fax :

Contact Email:

Dialysis Facility Name: | Prescriber's Full Name:

Facility Address: | Ste #: | HCP Address: | Ste #:

City: | State: | Zip: | City: | State: | Zip:

Facility Tax ID: | HCP NPI #:

C) Agreement and Authorization *(Mandatory for both)*

Keryx Patient Plus must have authorization to conduct a benefit verification and insurance research. By providing authorization, the patient ("you" or the "patient") or the patient's healthcare provider ("HCP") permit Keryx Patient Plus and/or its affiliates to contact the insurer(s), including Medicare, about you/the patient's diagnosis and related therapies and allows the insurer(s) to disclose the relevant information about you/the patient to Keryx Patient Plus. Keryx Patient Plus may need to provide the insurer(s) with your/the patient's name, date of birth, Social Security Number, diagnosis, insurance information, or other relevant information needed to confirm insurance benefits. Keryx Patient Plus may also contact you or the HCP directly for missing or additional information required to process this verification request.

FOR THE PATIENT: If you understand the foregoing and authorize the sharing of the above information between your designated facility, prescribing physician, insurer(s), Medicare, and Keryx Patient Plus, please sign below. By signing below, you also hereby authorize Keryx Patient Plus to contact you directly in the future about available assistance programs, your diagnosis and related therapies, and/or reimbursement and access related information.

FOR THE HCP: I certify and warrant that all patient information supplied to Keryx Patient Plus and/or Keryx Biopharmaceuticals, Inc. affiliates has been obtained pursuant to an appropriate patient authorization allowing for the release, transfer, and use of such information by Keryx Biopharmaceuticals, Inc. in accordance with State and Federal law for verification and/or preauthorization of patient's benefits. I also warrant and represent that I have the full authority to make the certifications and warrants stated above.

_____ _____

Signature (Patient or HCP) ☐ Patient ☐HCP ☐Facility Representative | Date

D) Patient Insurance Information *(Benefits Verification)*

☐ *Please attach a copy of the patient's Prescription Benefits card (front & back copy)*

Does the patient have any Prescription Drug Coverage? ☐ Yes ☐ No | Type of Coverage: ☐ Medicare ☐ Medicaid ☐Private/Commercial ☐VA/TRICARE ☐ Other

If Yes: Policy ID: | Plan Name:

New Start: | First Date of Dialysis _____/_____/_____ | Date Applied to Medicare _____/_____/_____

E) Patient Financial Information *(Patient Assistance Program)*: ***Proof of Income Required***

Total number of people in household: | Total Adjusted Gross Income for your Entire Household (before taxes): $ (Includes all annual income wages, pension, social security, disability, alimony, interest/dividends, rental property income, etc.) | □ Monthly □ Annual

Is the patient a U.S. citizen? ☐ Yes ☐ No
If No, is the patient a permanent resident of the U.S.? ☐ Yes ☐ No | Proof of Income (POI): □ 1040 □ w2 □ SSA Benefit Statement □ Pay Stub (within last 3 months)

F) Prescription Information *(Patient Assistance Program)*

Select Medication: ☐ AURYXIA® (ferric citrate)
Ship to: ☐ Patient ☐ Facility ☐ Prescribing HCP | Sig/Directions:
Quantity : | # of Refills:

Print Prescriber Name: | Prescriber State License #:

_____ _____

Prescriber Signature | Date

G) Patient Agreement and Authorization *(Patient Assistance Program)*

I understand that to qualify for free medicine I must meet the eligibility requirements of Keryx's Patient Assistance Program (PAP). I certify that the financial information that I have provided is accurate and complete. I further agree that Keryx Biopharmaceuticals, Inc. and/or Keryx Patient Plus is entitled to request additional information, and I agree to provide and/or agree to disclose that additional information as a condition of receiving free medicine. I agree that I am not guaranteed eligibility to receive free medicine, that I may need to reapply to PAP, and that PAP may be discontinued or changed at any time without notice to me. I understand that if approved, I am not eligible to seek reimbursement from any government program or third party insurer for any medicine dispensed under this PAP.

_____ _____

Patient Signature | Date

Please return the completed application form and required documentation to: Keryx Patient Plus, P.O. Box 877, Somerville, NJ 08876

Helpful Reminders:

Use the list below to ensure all required fields are complete and accurate.

- □ Include at least the last 4 digits of the patient's Social Security Number if applicable
- ☐ Include copies of the patient's insurance/prescription drug cards. Include secondary coverage, as well if applicable
- ☐ Include the preferred contact's email address and phone number
- ☐ Submit the application by fax to 866-310-7424 or email KPP@keryx.com
- □ Choose either annual or monthly for the patient's gross income
- ☐ Acceptable forms of Proof of Income
  a. 1040, W2, SSA Benefit Statement, Pay Stubs (Within Last 3 Months)
  b. Other forms of proof of income may be acceptable, contact case manager for more detail
- ☐ Complete all portions of the Rx properly
  a. Keryx Patient Plus fills the patient's prescription in 30-day supplies; the quantity should equal the amount per day multiplied by 30
  b. If the patient is taking AURYXIA with snacks, please be sure to include this information in the directions
- □ Remember, the patient, their caregiver or the HCP must call, or email a refill request to Keryx Patient Plus each month for the patient to receive their AURYXIA refill through the Patient Assistance Program

  Call: 855-686-8601 (8AM-6PM ET, Mon-Fri)

  Email: Refillrequest@keryx.com

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