Doptelet connect

PRESCRIPTION AND ENROLLMENT FORM

- Call Doptelet Connect™ at **1-833-368-2663** Monday through Friday 8:30 AM to 7 PM ET, or visit **DopteletConnectHCP.com**
- Healthcare providers please complete and sign the appropriate sections of this form, have the patient sign Section 4, and fax it to Doptelet Connect at **1-855-686-8729** or **email to [DopteletConnect@AssistRx.com]**
- **To enroll online**, please visit **[SobiPatientSupport.iassist.com]**

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 ◯ Text ◯ 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 INSURANCE INFORMATION Please provide copies of all medical and prescription insurance cards (front and back).

Does the patient have any form of insurance coverage? ◯ Yes ◯ No

Is there a PA on file? ◯ Yes ◯ No *(Please include PA determination letter if available.)*

Is your patient incurring a coverage related delay that will cause a lapse in therapy? ◯ Yes ◯ No

Policyholder Full Name: _____ Policyholder Date of Birth: ____ /____ /____

Primary Medical Insurance: _____

Insurance Phone: _____ Group #: _____ ID #: _____

Prescription Insurance: _____ RxGroup: _____ RxBIN: _____ RxPCN: _____

Secondary Medical Insurance: _____

Insurance Phone: _____ Group #: _____ ID #: _____

Prescription Insurance: _____ RxGroup: _____ RxBIN: _____ RxPCN: _____

3 PREFERRED DELIVERY METHOD

◯ CVS Specialty Pharmacy ◯ Accredo Health Group Inc. ◯ Optum Specialty Pharmacy ◯ Biologics Specialty Pharmacy

◯ IOD/MID Pharmacy Name: _____ Phone: _____ Fax: _____

4 PATIENT AUTHORIZATION STATEMENT

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement below and on page 3.

SIGN HERE **Patient Signature:** _____ **Date:** ____ /____ /____

OR

SIGN HERE **Authorized Representative Signature:** _____ **Date:** ____ /____ /____

I am signing on behalf of the patient, and I affirm that I have the legal right to do so, through a valid power of attorney to act on behalf of the patient.

My signature on this 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, 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 Personally Identifiable 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 pursuant to this Authorization. *(continued on page 3)*

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REQUIRED Patient Last Name: _____ First Name: _____ Date of Birth: ___/___/_____

5 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: _____

6 PRESCRIBER CERTIFICATION STATEMENT

I hereby attest that I am the prescribing healthcare provider, and I agree to submit requests to Doptelet Connect because I have determined that Doptelet® (avatrombopag) is medically appropriate for my patient, and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to Doptelet Connect for the purpose of providing my patient with assistance in accessing, initiating or continuing Doptelet therapy, and/or evaluating my patient's eligibility for patient support programs that may be available, if any.

I certify that the prescription on this form complies with all applicable state and local laws. On behalf of my patient, I authorize Doptelet Connect, as my designated agent to forward a prescription for Doptelet, by fax or other means under applicable law, to an appropriate pharmacy that dispenses Doptelet, if necessary. I agree to notify Doptelet Connect if I become aware at any time in the future of changes in my patient's circumstance that would affect their eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, or United States residency. I understand that I am under no obligation to prescribe any Sobi products and that I have not received, nor will I receive any benefit from Sobi for doing so.

Furthermore, I will not seek reimbursement from any third-party payer or government entity for any product that may be provided free of charge to my patient through a patient support program offered by Doptelet Connect. I acknowledge I may be contacted by email, postal mail, or fax using the information provided on this form, and I understand my information will be used and disclosed by Doptelet Connect in accordance with Sobi's privacy policy, available at https://sobi-northamerica.com/privacy-policy.

My signature below certifies that I have read, understand, and agree to this Prescriber Certification Statement.

SIGN HERE **Prescriber Signature:** _____ **Date:** ____ /____ /_____

Stamp signature not allowed. *This form cannot be processed without an original signature.*

7 CLINICAL INFORMATION **Attach any applicable clinical notes.**

◯ **Chronic immune thrombocytopenia (ITP) in adult patients**

ITP diagnosis code (ICD-10): _____

Other: _____

Prior treatment: _____

_____

_____

◯ **Thrombocytopenia (TCP) in adult patients with chronic liver disease (CLD)**

CLD diagnosis code (ICD-10): _____

TCP diagnosis code (ICD-10): _____

Known procedure date (MM/DD/YYYY): _____

Begin taking (MM/DD/YYYY): _____

Has the patient been prescribed Doptelet previously? ◯ Y ◯ N If Yes, Date (MM/DD/YYYY) of last prescription: ____ /____ /_____

Patient platelet count value (K/μL): _____ Allergies: _____ Other medications: _____

8 PHARMACY PRESCRIPTION

The prescriber must comply with his/her state specific prescription requirements, such as e-prescribing, state specific prescription forms, fax language, etc. Noncompliance with state specific requirements may result in outreach to the prescriber.

◯ Doptelet® (avatrombopag) 20-mg tablets 10 ct (NDC # 71369-0020-10)

◯ Doptelet® (avatrombopag) 20-mg tablets 15 ct (NDC # 71369-0020-15)

◯ Doptelet® (avatrombopag) 20-mg tablets 30 ct (NDC # 71369-0020-30)

Directions: _____

Quantity: _____ ◯ Refill(s): _____

SIGN HERE **Prescriber Signature:** _____

Date: ____ /____ /_____ **Dispense as written**

OR

Prescriber Signature: _____

Date: ____ /____ /_____ **Substitution permitted**

Stamp signature not allowed.
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9 FREE TRIAL OFFER PRESCRIPTION

The Free Trial Offer (FTO) provides a fifteen (15) day supply of Doptelet, at no cost, to **ITP patients** who: are new to Doptelet; are 18 years or older; reside in the United States or its Territories; and have an approved on-label prescription. Patients may only participate in the FTO once. The one-time, 15-day supply will be shipped directly to eligible patients. Sobi reserves the right to amend, rescind, or revoke the FTO at any time without notice.

◯ **I would like my patient to only participate in the FTO and not be enrolled in Doptelet Connect**

◯ Doptelet® (avatrombopag) 20-mg tablets (starting dose may vary)

Please indicate dosing directions below if your patient is on concomitant inhibitor/inducer medications.

Directions: _____ REQUIRED

Prescriber Signature: _____ SIGN HERE

Date: ____ /____ /_____

Stamp signature not allowed.
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ICD-10=*International Classification of Diseases, Tenth Edition*; NDC=National Drug Code.

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Patient Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____

4 PATIENT AUTHORIZATION STATEMENT (continued)

I understand that Service Providers may be compensated by Sobi. 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® (avatrombopag) with my payer; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary and applicable; and (vi) assist with analyses of the efficiencies and performance of services provided by Service Providers.

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 may 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 Doptelet Connect in writing 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 Doptelet Connect at 495 N Keller Rd, Suite 100, Maitland, FL 32751. 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 assistance under the Doptelet Patient Assistance Program (PAP), I agree to allow Service Providers to use my demographic information, including, but not limited to, my 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. Service Providers reserve the right to ask for additional documents and information at any time. If I am eligible to participate in the Doptelet PAP I understand that: (i) continued enrollment in the PAP is not guaranteed, (ii) re-enrollment is not automatic, (iii) I cannot submit a claim or seek reimbursement or credit for product I receive under the Doptelet PAP from my insurance provider or payer, and (iv) no payer, third party, or patient may be charged for PAP product provided under the PAP program. 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 residency.

I agree to allow Service Providers to contact me via email or cell phone using the contact information provided in this form, unless I otherwise inform Doptelet Connect that I do not wish to receive text messages. I understand that receiving text messages is optional and I can participate in Doptelet Connect without agreeing to receive text messages. I understand that by providing my cell phone number on this form I agree to receive text messages with the following conditions:

- Service Providers may send an autodialed pre-recorded text message (standard text message and data rates apply).
- I can opt out at any time by calling 1-833-368-2663 or replying "STOP" to the text messages.
- Service Providers are not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- I am aware that anyone who can open or have access to my phone might see the text messages.
- If my mobile operator is not participating in text messaging services, I will not receive text messages.
- I CANNOT report product complaints or adverse events (like side effects) by text message. To report these, please call Doptelet Connect at 1-833-368-2663.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Massachusetts, excluding Massachusetts conflict of law rules, and applicable federal law.