AkebiaCares Enrollment Form

Phone: 1-833-4AKEBIA (425-3242) | Fax: 866-310-7424

☐ **BENEFITS VERIFICATION ONLY**
Complete Sections A, B, D, E, F, and G.
Both Patient Signatures Required.

☐ **BENEFITS VERIFICATION AND PATIENT ASSISTANCE PROGRAM (PAP)**
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.**

***Indicates required field**
(PLEASE CLEARLY TYPE OR PRINT IN BLACK INK)

A Patient information

Legal name (first, middle, last)*:	Suffix:	Gender*:	Date of birth (mm/dd/yyyy)*:	Are you a US citizen?*
		☐ Male ☐ Female		☐ Yes ☐ No

Street address*:	Apt#:	City*:	State*:	ZIP*:

Preferred language:	Patient representative name (if applicable):	Relationship to patient:

Primary phone*:	Patient/Patient representative email:	Is the patient on dialysis?
		☐ Yes ☐ No

B Prescription drug insurance information (send a front and back copy of the patient's prescription insurance card or complete below)

Primary insurance*:	Rx PCN#*:	Rx BIN#*:	Rx Group#*:

Cardholder name*:	Prescription insurance member ID#*:	Medicare ID#*:	☐ Patient does not have insurance*

Name of patient-preferred pharmacy*:	Address*:

City*:	State*:	ZIP*:	Phone*:	Fax*:

C Income information† (required for Patient Assistance Program evaluation)

If you have Medicare Part D and have applied for Medicare's Low-Income Subsidy (Extra Help), which of the following outcomes did you receive?

☐ Full support ☐ Partial support ☐ Denied ☐ Did not apply

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)

†AkebiaCares or its agents will run a soft credit check to assist with income verification. A soft credit check will not appear on the patient's credit statement or impact their credit score. 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.

‡Your household size includes all individuals you reported on your U.S. Tax Return. If you did not file a tax return, please include all individuals that live with you.

D Patient HIPAA authorization to use and share protected health information

☐ **Please send a text or 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 clinical trials and market research; review eligibility for financial assistance; carry out other business purposes related to Akebia products; 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 the 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 or any portion of 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 or limit 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*:	

E Patient consent to participate in AkebiaCares

AkebiaCares is a program administered by Akebia that provides Patient Support to eligible patients who have been prescribed an Akebia medication. Patient Support includes: (1) providing reimbursement and assistance with financial support (including, but not limited to, 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.

I acknowledge that 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. I expressly permit Akebia to (1) contact me or my representative, using contact information that I provide, through any medium, including, but not limited to, mail, telephone, text message, or email; (2) use My Information to tailor AkebiaCares-related communications to my needs; and (3) share information with My Providers about dispensing an Akebia product to me. Akebia may also de-identify My Information and use the de-identified information for Akebia's business purposes. I understand that AkebiaCares is an optional program and that my treatment, insurance enrollment, and insurance eligibility are not conditioned upon providing consent. I also understand that refusing to consent will make me ineligible to participate in AkebiaCares. If I provide consent, I may revoke it at any time by mailing a letter to AkebiaCares, P.O. Box 5490, Louisville, KY 40255, sending an email to support@akebiacares.com, or following the opt-out instructions in any correspondence that I receive. If my contact or insurance information changes at any time while I am participating in AkebiaCares, I will notify AkebiaCares as soon as possible by using the physical or email address provided above. By signing below, I confirm that I would like to enroll in AkebiaCares and that I want Akebia to provide me with Patient Support. By signing below, I also authorize the Centers for Medicare & Medicaid Services to disclose Medicare eligibility information to Akebia.

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.

☐ Opt-in to Receive Marketing Communications (optional): By checking this box, I authorize Akebia, and companies working with Akebia, to contact me regarding product and educational information, and for other opportunities, including, but not limited to, customer surveys. I understand that I am not required to provide this consent as a condition of receiving any Akebia medicine or services from Akebia. I understand that I may opt-out of these communications at any time via the link/contact information available in all communications.

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.

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*Indicates required field
(PLEASE CLEARLY TYPE OR PRINT IN BLACK INK)

Patient name (first, middle, last)*:	Date of birth (mm/dd/yyyy)*:

F Prescriber information

Prescriber name*:	Prescriber practice name:	Prescriber NPI*:

Practice street address:	STE#:	City:	State:	ZIP:

Dialysis facility name (if applicable):

Dialysis facility address (if applicable):	STE#:	City:	State:	ZIP:

Contact person*:	Title*:

Contact phone*:	Contact fax*:	Contact email*:	Contact location*:
			☐ Prescriber ☐ Dialysis facility

G 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 acknowledgments in consultation with and on behalf of the patient's prescriber. By signing below, I certify and acknowledge that (1) the prescribed Akebia medication 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 the prescribed Akebia medication or any other Akebia product, and any decision to prescribe the Akebia medication 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*:

H Prescription information

Pharmacy Dispense			PAP or Starter/Bridge Therapy Dispense		
Select medication*:	Day supply*:	No. of refills*:	Select medication*:	Quantity (200 ct bottle)*:	No. of refills*:
☐ AURYXIA® (ferric citrate) tablets			☐ AURYXIA® (ferric citrate) tablets		
Sig/directions (please write clearly)*:			Sig/directions (please write clearly)*:		
Send Rx to*:			Ship to*:		
☐ Patient-preferred pharmacy			☐ Patient ☐ Facility (if permitted) ☐ Prescriber		
☐ Payer-preferred pharmacy			☐ Check to enroll in auto refill		

MEDICATION ALLERGIES? (IF YES, LIST ALL DRUG ALLERGIES)*:	CURRENT MEDICATIONS (PLEASE LIST OR ATTACH)*:
☐ YES ☐ NO	

I Prescriber signature (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*: X_____ X_____ Date*:_____
Dispense as written Substitutions allowed

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit https://akebia.com/privacy-policy/.