Doptelet® (avatrombopag) tablets

Doptelet® (avatrombopag) connect™

Prescription and Enrollment Form

- Visit Doptelet Connect at **dova1source.com** or call **1-833-368-2662**
- Fax to Doptelet Connect at **1-855-686-8729**

◯ CVS Specialty Pharmacy ◯ Accredo Specialty Pharmacy ◯ Kroger Specialty Pharmacy ◯ Biologics Specialty Pharmacy

◯ On-site dispensing pharmacy name: _____ Pharmacy contact name: _____

Phone #: _____ Fax #: _____

◯ Enroll me in the Doptelet Copay Program. Eligibility requirements apply.

◯ I authorize Doptelet Connect to leave a detailed message, including my name or the name of the prescription, Doptelet.

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 ◯ Email Best time to call: ◯ Morning ◯ Afternoon ◯ Evening

Preferred Language: ◯ English ◯ Spanish ◯ Other: _____ US Resident: ◯ Yes ◯ No

CAREGIVER INFORMATION

Last Name: _____ First Name: _____ Relationship to Patient: _____

INSURANCE INFORMATION

◯ No Insurance Please provide a copy of all insurance cards (front and back).

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 #: _____

AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, I authorize my healthcare providers and staff, pharmacies, and health insurers to use and to disclose to Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "Sobi") health information about me related to my medical condition and treatment, health insurance and coverage, and prescription (including fill/refill information) for Doptelet ("Information") to (1) enroll me in and provide services under the Doptelet Connect patient-support program ("Program"); (2) obtain information on my insurance coverage; (3) coordinate prescription fulfillment as indicated by my physician; (4) provide me with adherence reminders and support; and (5) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Sobi support programs or Sobi products. Once my Information has been disclosed to Sobi, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Sobi will protect my Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise required by law.

I understand and agree that the pharmacy that dispenses Doptelet may receive payment from Sobi in exchange for disclosing my Information to Sobi and providing Program services.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment from healthcare providers, payment for treatment or eligibility for health insurance benefits, or access to Sobi medications. However, if I do not sign this Authorization, I understand that I will not be able to participate in the Program.

I understand that this Authorization expires five (5) years from the date signed below, or earlier if required by state or local law, unless and until I cancel (take back) this Authorization before then. I may change my mind and cancel this Authorization at any time by calling 1-833-368-2663 or by notifying Doptelet Connect in writing at PO Box 5490, Louisville, KY 40255-5490. Cancellation of this Authorization will end further uses and disclosures of my Information by my healthcare provider and staff, pharmacies, and health insurers based on this Authorization, and my participation in the Program when they receive notice of my cancellation, but will not affect any uses or disclosure of my Information made by my healthcare providers and staff, pharmacies, and health insurers based on this Authorization before receipt of the cancellation.

Full Name (Printed) of Patient: _____

SIGN HERE Signature of Patient _____ Date _____

CONSENT FOR ENROLLMENT INTO DOPTELET CONNECT

By signing below, I am enrolling into Doptelet Connect (the "Program"). I authorize Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Sobi, Inc., "Sobi") to provide me with services for which we are eligible under the Program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to enrollment in the copay assistance program if I am eligible. For more information about Sobi Terms and Conditions, including privacy practices, please read our Terms and Conditions by visiting https://sobi-northamerica.com/terms-and-conditions.

Full Name (Printed) of Patient: _____

SIGN HERE Signature of Patient _____ Date _____

NEXT PAGE FOR HEALTHCARE PROVIDERS ONLY

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

FOR HEALTHCARE PROVIDER USE ONLY

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____ Office/Institution Name: _____

Street: _____ Suite: _____ City: _____ State: _____ ZIP Code: _____

NPI #: _____ DEA #: _____ Tax ID #: _____

Medical Provier ID #: _____

Office Contact Name: _____ Phone #: _____

Fax #: _____ Email: _____

PRESCRIBER AUTHORIZATION

My signature certifies that the person named on this form is my patient; that the information provided, to the best of my knowledge, is complete and accurate; and that therapy with Doptelet is medically necessary. I certify that I have obtained the written authorization of my patient in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Sobi and the Doptelet Connect patient support program, and I understand that the information that I provide on this form will be used by the program for purposes of verifying my patient's insurance coverage and eligibility; coordinating the dispensing of my patient's prescription medicine; and introducing Doptelet Connect support services to my patient, including contacting my patient by telephone or mail for these purposes. I authorize Doptelet Connect to transmit the above prescription to the appropriate pharmacy for my patient. 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. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by Doptelet Connect.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. Prescribers in states with official prescription form requirements must submit an actual prescription along with this enrollment form.

SIGN HERE Prescriber Signature _____ Date _____

CLINICAL INFORMATION Attach any required clinical notes.

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

ITP diagnosis code (ICD-10): D69.3

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): _____

PRESCRIPTION INFORMATION

Prescribers in all states must follow applicable law for a valid prescription. For prescribers in states with official prescription form requirements, such as New York, please submit a prescription along with this form in compliance with your state statutes and regulations.

◯ 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/day: _____ Patient platelet count: _____ ◯ Refill(s): _____

Allergies: _____ Other medications: _____

◯ Ship to patient's address in Patient Information section upon approval and completion of Rx.

◯ Ship to prescriber's office in Prescriber Information section upon approval and completion of Rx.

Stamp Signature Not Allowed

SIGN HERE Prescriber Signature _____ Date _____

Dispense as Written

OR

Prescriber Signature _____ Date _____

Substitution Permitted

ICD-10=*International Classification of Diseases, Tenth Edition*; NDC=National Drug Code.

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

FOR HEALTHCARE PROVIDER USE ONLY – PAYER DELAYS

PRODUCT QUICKSTART ENROLLMENT PROGRAM

◯ **I confirm that my patient is newly prescribed Doptelet® (avatrombopag) and wants to enroll into the QuickStart program to begin treatment as soon as possible.**

The Doptelet QuickStart program is available to insured patients 18 years of age or older who are US residents with a confirmed diagnosis of ITP or CLD who experience a payer approval delay of 5 days or more from time of form submission. **To enroll your patient, fill out this QuickStart section as well pages 1 and 2 of this form. If the form is not filled out in its entirety, the QuickStart request cannot be processed.**

QUICKSTART PRESCRIPTION

◯ **ITP in adult patients**

◯ **TCP in adult patients with CLD**

◯ Doptelet® (avatrombopag) 20-mg tablets 15 ct (per program guidelines) Quantity/day: _____

Directions: _____ ◯ 1 refill, if necessary (per program guidelines)

Stamp Signature Not Allowed

SIGN HERE Prescriber Signature _____ Date _____

Dispense as Written

OR

Prescriber Signature _____ Date _____

Substitution Permitted

WHAT HAPPENS NEXT FOR QUICKSTART?

You will be **eligible for the QuickStart program 5 days after the confirmation of the prior authorization (PA) submission** and once the completed Prescription and Enrollment form has been submitted to Doptelet Connect. Doptelet Connect will make a welcome call to the patient and coordinate product shipment.

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