Patient Referral Form

Please attach Patient Insurance Sheet and EMR

FAX: 866-549-7219 ● TOLL-FREE: 866-547-0644

Kineret® (anakinra) On TRACK™

TO ePRESCRIBE: Search for RxCrossroads, LLC in ZIP CODE 40218
NCPDP#: 1827104

Patient Information

*Full Name:	*Gender: M ☐ F ☐	*DOB:
Parent/Guardian Name:	Parent/Guardian Phone:	
*Address:	City/State:	*Zip:
*Primary Phone:	Alternate Phone:	*U.S. Citizen: Y ☐ N ☐

Patient Medical Information

Primary Diagnosis/ICD-10:	
Secondary Diagnosis/ICD-10:	
Primary Diagnosis/ICD-9 (please list):	Secondary Diagnosis/ICD-9 (please list):

Pharmacy Benefit Information and Medical Benefit Information Check Box If Uninsured ☐

Please attach front and back copy of the patient's insurance and drug/prescription benefit cards (if available)

Prescription Insurance Name:	*Medical Insurance Name:
*PCN: *BIN:	*Policy #:
*Group #:	*Group #:
*Policyholder Name:	*Policyholder Name:
*Policyholder Date of Birth:	*Policyholder Date of Birth:
*Relationship to Patient:	*Relationship to Patient:

Physician Information

*Prescriber Name:		PA # on file (if applicable):	
*Phone:		*Fax:	
*Primary Address:		*City:	*State: *Zip:
Specialty:	*Tax ID#:	*NPI #:	*DEA #:

Prescription Drug Information and Treatment Settings

Is patient currently on KINERET® therapy? : Y ☐ N ☐	KINERET® on hand: Y ☐ N ☐
Deliver to: ☐ Patient's home ☐ Physician's office	Initial Treatment Setting: ☐ Prescriber Office ☐ Patient's Home

☐ I would like my patient and/or his/her caregiver to receive training on the self-administration of KINERET®

☐ Opt-Out: My patient and/or his/her caregiver does not need training on the self-administration of KINERET®

☐ I would like to be contacted regarding nursing notes/pharmacy progress reports on the status of this KINERET® patient

KINERET® 100 mg/0.67mL Solution ☐ 28 Syringes ☐ 7 Syringes ☐ Other: _____

Directions: Inject_____mg subcutaneously every_____Refills: _____

☐ Dispense as written

TN prescriber's quantity must be written in both numerals and words. **NY prescribers** submit prescription on an original NY State prescription blank.

Prescriber Consent

Prescriber Name (Please Print):	*Prescriber Signature (Required):	Date:

I authorize RxCrossroads® to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use, disclose and receive any protected health information (as defined in 45 CFR 160.103) ("PHI") about any of my patients referred to the Sobi Kineret Reimbursement Program ("Patients"), including exchanging such information with pharmacies, insurers, and nurse agencies/coordinators as needed to perform the following services for me: (i) obtain any benefit information about my Patients for the purpose of determining the Patient's insurance coverage for Kineret; (ii) submission of necessary documentation to support Prior Authorization and Pre-Determinations for my Patient's coverage for Kineret; (iii) perform adherence or compliance calls to my Patients related to Kineret treatment. RxCrossroads® may also use and disclose such PHI to assist me with other functions related to my treatment and as otherwise permitted or required by law. As my business associate, RxCrossroads® is required to comply with the applicable requirements of 45 CFR 164.504€(2)(ii)(A) through (I) and 45 CFR 164.314(a)(2)(i)(A) through (C) regarding business associates, and agrees that it will safeguard any PHI that it obtains on my behalf and will use and disclose this information only as permitted herein. RxCrossroads® acknowledges that if it materially breaches its obligations as stated herein, I may terminate its services as stated above and this agreement.

By signing this form, I certify that I have received the necessary authorization to release the medical and/or other patient information relating to Kineret therapy to RxCrossroads®. I authorize RxCrossroads®, as operator of patient support services on behalf of Sobi, Inc. and its affiliates, to be my designated agent(s) and (1) to provide any information on this form to the insurer of the above-named patient and (2) to forward the above prescription, by fax or any other mode of delivery, to the pharmacy.

PP-3059