Doptelet® (avatrombopag) tablets

Doptelet® (avatrombopag) connect™

Doptelet Patient/Caregiver Consent Form

Doptelet Connect is a patient support program created by Sobi to provide individualized support to help appropriate patients get access to Doptelet® (avatrombopag). Doptelet Connect can help patients understand the treatment process and their financial options, support providers in navigating insurance and reimbursement questions, and assist in the coordination of care and the specialty pharmacy process.

In order for the patient to take advantage of this program, consent/authorization must be obtained.

The patient should complete this form legibly and sign it. All completed forms should be faxed to 1-855-686-8729.

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: _____ Middle Initial: _____

Relationship to Patient: _____

◯ Enroll me into 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.

PRESCRIBER INFORMATION

Primary Care Provider/Specialist Name: _____

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

Phone #: _____ Fax #: _____

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 Sobi in writing at Doptelet Connect 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.

Full Name (Printed) of Patient: _____

SIGN HERE Signature of Patient _____ Date _____

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