

**Kineret<sup>®</sup> and Kepivance<sup>®</sup>**  
**Patient Assistance Program**  
 P.O. Box 66982 St. Louis, MO 63166-6982  
 Phone: 1-866-547-0644 Fax: 1-866-549-7219  
 P.O. Box 66982 St. Louis, MO 63166-6982

## Form C: Prescription and Order Form

Section 1 - Physician and Prescription Information				
Physician Name:	DEA/State License #/NPI:	Phone: ( )	Fax: ( )	
Address: (No P.O. Box)		City:	State:	Zip:
Product Requested	Instructions	Quantity in Boxes	Day supply	Refills
<b>Kepivance*</b>  <input type="checkbox"/> 6 vials per box			One course of therapy	No refills allowed
<i>Kepivance must be shipped to the physician's address</i>				
<b>Physician Signature:</b>  <div style="display: flex; justify-content: space-between; align-items: center;"> <span><input type="checkbox"/> _____</span> <span>/ /</span> <span><input type="checkbox"/> _____</span> </div> <div style="display: flex; justify-content: space-between; align-items: center; font-size: small;"> <span>(substitution allowed)</span> <span>(date)</span> <span>(dispense as written)</span> </div>				
Section 2 - Patient Information				
Patient Name:		SS #, Green Card, VISA:		
Street Address:		Date of Birth:	ICD-9 Code	
City:	State:	Zip:	Phone: ( )	
Medication Information				
Patient allergies: <input type="checkbox"/> No Known _____				
Please list the names of other medications the patient is currently taking: <input type="checkbox"/> None _____				

**Please fax this form to 1-866-549-7219 or mail to address above**  
**If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form.**

\*The Kepivance<sup>®</sup> Patient Assistance Program cannot provide assistance for inpatient hospital use.

By submitting this request I agree to the following:

- I certify that the Biovitrum product reported on this form, for which I am requesting free replacement, was furnished free of charge to a Kepivance Patient Assistance Program patient. I represent that the information provided in this form is complete and accurate to the best of my knowledge and agree to notify the Kepivance Patient Assistance Program of any changes I become aware of which could affect patient eligibility. I further certify that I am authorized to act for the institution for which I am signing.
- I certify that no replacement will be requested for product administered in the hospital inpatient setting.