Auvi-Q®
epinephrine injection, USP
0.1 mg/0.15 mg/0.3 mg auto-injectors

KALÉO CARES Patient Assistance Program

Please fax* completed forms to: 1-800-943-1730

****Faxes must be sent from Prescriber office.***

Kaléo understands the importance in having emergency medications available to patients but recognizes that some patients may have financial difficulties that prevent them from obtaining those needed medications. The KALÉO CARES Patient Assistance Program is here to help those patients that are experiencing financial difficulties. To be eligible for assistance to receive AUVI-Q® at no cost you must:

- Be a legal US resident.
- Not have any government or commercial drug coverage.†
- Have an annual household income of less than $100,000.

†Patients who are eligible for Medicaid coverage may be eligible for assistance to receive AUVI-Q at no cost.

Kaléo reserves the right to discontinue the program at any time for any or no reason. **This is not insurance.**

Section 1: Patient Information			
First Name		**Last Name**	
Street Address (Cannot be PO Box)			
City		**State**	**Zip**
Primary Phone		**Secondary Phone**	
US Resident ☐ **Yes** ☐ **No**		**Social Security Number**	
Gender ☐ **Male** ☐ **Female**		**Date of Birth**	
Section 2: Insurance and Income Attestation			
Do you have prescription drug coverage? ☐ **Yes** ☐ **No**		**Number of Dependents (Total Number of People in Household)**	
Do you have commercial insurance? ☐ **Yes** ☐ **No**			
Are you eligible for government insurance, such as Medicare or Tricare? ☐ **Yes** ☐ **No**	**Specifically, are you eligible for Medicaid?** ☐ **Yes** ☐ **No**	**Annual Household Income‡**	
All medication will be shipped directly to patient.		**‡Note: Patient may be required to provide proof of income.**	
I declare and affirm that the information provided on this application form is true and accurate. I give consent to the KALÉO CARES Patient Assistance Program to disclose my enrollment in this program as needed to comply with legal and regulatory obligations. I agree to notify this program immediately if my prescription drug coverage changes in any way before I receive a prescription or a refill.			
Patient Signature:		**Date**	

Section 3: Patient Privacy and Consent

The information you provide will be used by kaléo, the KALÉO CARES Patient Assistance Program and parties acting on their behalf to determine eligibility, to manage and improve the KALÉO CARES Patient Assistance Program, products and services, to communicate with you about your experience with the KALÉO CARES Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to kaléo programs.

By signing below, I affirm that my answers and my documented income are complete, true and accurate to the best of my knowledge.

I understand that:

- Completing this enrollment form does not guarantee that I will qualify for the KALÉO CARES Patient Assistance Program.
- kaléo may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medicines supplied by KALÉO CARES Patient Assistance Program shall not be sold, traded, bartered, or transferred.
- kaléo reserves the right to change or cancel the KALÉO CARES Patient Assistance Program, or terminate my enrollment, at any time.
- The support provided by this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by kaléo through the KALÉO CARES Patient Assistance Program:

- I will promptly contact kaléo if my financial status or insurance coverage changes.
- I will not seek reimbursement or credit for the medicine(s) from my insurance provider or payor for any costs of medications.
- I will not seek to have this medicine or any cost from it counted in my out-of-pocket expenses for prescription drugs for any payor.
- I will notify my insurance provider of the receipt of any medicines through the KALÉO CARES Patient Assistance Program.

I may refuse to sign this consent. If I refuse, I will not be able to participate in this program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment, or affect my insurance enrollment or eligibility for insurance benefits.

I certify that the information on this form is accurate and complete to the best of my knowledge.

Patient Signature:	**Date**

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Patient Name	**Date of Birth**
Allergies	
Weight ☐ **7.5 to 15 kg (16.5 to 33 lbs)** ☐ **15 to 30 kg (33-66 lbs)** ☐ **Greater than or equal to 30 kg (66 lbs)**	
Other Medications	

Section 4: Healthcare Provider Information

Prescriber First Name	**Prescriber Last Name**	
Street Address		
City	**State**	**Zip**
Office Contact Name	**Office Phone**	**Office Fax**
State License	**NPI**	**DEA**

Section 5: Prescription

AUVI-Q® ☐ **0.1 mg auto-injector** ☐ **0.15 mg auto-injector** ☐ **0.3 mg auto-injector**
(epinephrine injection, USP)
Directions _____

# of Cartons: ☐ **1 carton (2 auto-injectors & 1 Trainer)** _____

Diagnosis **ICD-10** _____ **Other** _____

Date	**Anticipated Start Date**

I certify that this AUVI-Q® prescription fits the indication and is medically appropriate for this patient. I affirm that the patient is not eligible for Medicare and the information provided by the patient on this application form is complete and accurate to the best of my knowledge. I give consent to the KALÉO CARES Patient Assistance Program, kaleo, Inc., its affiliated companies, and its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

Prescriber's Signature: _____

Dispense as Written _____ Substitution Allowed _____

NY prescribers – *please submit prescription on an original NY State prescription blank*
TN prescribers – *quantity must be written in both numerals and words. Example: 3 (three) doses*