Doptelet connect

FREE TRIAL OFFER PROGRAM REQUEST FORM

FOLLOW THESE 3 STEPS TO SUBMIT THE FREE TRIAL OFFER PROGRAM REQUEST FORM

Step 1. Complete this form. Be sure to sign Sections 3 and 4 **and include Prescription Directions** in Section 4.
Step 2. Fax completed form to Doptelet Connect™ to **1-855-686-8729**.
Step 3. Share page 2 with your patient: *Information for Patients and What to Expect*.

IMPORTANT: This form will not enroll your patient in Doptelet Connect. If you would like to enroll your patient in Doptelet Connect *and* request the Free Trial Offer, please use the Doptelet Prescription and Enrollment Form.

For more information about Doptelet Connect or the Free Trial Offer, please call Doptelet Connect at **1-833-368-2663**, Monday through Friday, 8 AM-8 PM ET.

1 PATIENT AND AUTHORIZED REPRESENTATIVE INFORMATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Street: _____ Unit: _____ City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

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

AUTHORIZED REPRESENTATIVE INFORMATION

Last Name: _____ First Name: _____

Relationship to Patient: _____ Phone: _____

2 PRESCRIBER INFORMATION

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

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

NPI #: _____ Medicaid Provider ID #: _____ Tax ID #: _____

Office Contact Name: _____ Phone: _____

Fax: _____ Email: _____

3 PRESCRIBER CERTIFICATION STATEMENT

I hereby attest that I am the prescribing healthcare provider. I am submitting this Request Form for my patient to be evaluated for participation in the Doptelet Free Trial Offer Program ("Program") to help me determine if it is the appropriate treatment. I certify that my patient is new to Doptelet® (avatrombopag) therapy, and I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) for the purpose of my patient participating in this Program. Furthermore, if my patient is eligible to participate in the Program I will not seek reimbursement from any third-party payer or government entity for the product my patient would receive free of charge through the Program. I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by Doptelet Connect in accordance with Sobi's privacy policy, available at https://sobi-northamerica.com/privacy-policy.

SIGN HERE **Prescriber Signature:** _____ **Date:** ____ /____ /_____

Stamp signature not allowed. *This form cannot be processed without an original signature.*

4 FREE TRIAL OFFER PRESCRIPTION

The Free Trial Offer (FTO) provides a fifteen (15) day supply of Doptelet, at no cost, to **ITP patients** who: are new to Doptelet; are 18 years or older; reside in the United States or its Territories; and have an approved on-label prescription. Patients may only participate in the FTO once. The one-time, 15-day supply will be shipped directly to eligible patients. Sobi reserves the right to amend, rescind, or revoke the FTO at any time without notice.

REQUIRED ◯ Patient has chronic immune thrombocytopenia (ITP)

◯ Doptelet® (avatrombopag) 20-mg tablets (starting dose may vary)

Please indicate dosing directions below if your patient is on concomitant inhibitor/inducer medications.

REQUIRED Directions: _____

SIGN HERE **Prescriber Signature:** _____ **Date:** ____ /____ /_____

Stamp signature not allowed. *This form cannot be processed without an original signature.*

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Provider to give this page to patient.

Doptelet connect

Doptelet Free Trial Offer Program

INFORMATION FOR PATIENTS AND WHAT TO EXPECT

PROGRAM INFORMATION

Your doctor has requested that you participate in the Doptelet® (avatrombopag) Free Trial Offer Program ("Program") where eligible patients will receive a fifteen (15) day supply of Doptelet at no cost. This Program allows you and your doctor to evaluate your clinical response to Doptelet to determine whether it is appropriate treatment. The one time, 15-day supply will be shipped directly to eligible patients. Sobi reserves the right to amend, rescind, or revoke the Program at any time without notice.

In order to be eligible for the Program, patients must meet the following eligibility requirements:

1. Patient must be prescribed Doptelet for an approved on-label indication of chronic ITP (immune thrombocytopenia) and be under the care of a licensed healthcare provider authorized to prescribe medicine in the US;
2. Patient must be 18 years or older;
3. Patient must be new to Doptelet therapy;
4. Patient must reside in the United States or US Territories; AND
5. Patient may only participate in the Free Trial Offer once.

WHAT TO EXPECT

If Doptelet Connect™ determines you are eligible for the Program, Doptelet Connect will call you to schedule shipment.

SCAN the QR Code to add Doptelet Connect to your contacts

QUESTIONS

If you have any questions or would like more information, please call Doptelet Connect at **1-833-368-2663** Monday through Friday, 8 AM-8 PM ET, or visit **Doptelet.com**.

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