

Please fax completed forms from prescriber's office to: **(800) 943-1730**

kaleo, Inc (kaléo), the maker of AUVI-Q, understands that some patients may have financial difficulties that prevent them from obtaining necessary medications. Through the kaléo Cares Patient Assistance Program (PAP), patients who are experiencing financial difficulties may be able to receive AUVI-Q at no cost. To be eligible for assistance, a patient must:

- (1) Be a legal US resident;
- (2) Not have any government or commercial drug coverage*; and
- (3) 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.

*Required field

1. Patient Information - May Be Completed by Patient

*Patient Name (Last, First):		*SSN:	
*Date of Birth:	*Weight (lbs):	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
*Address (Cannot be a PO Box):		*City:	*State: *Zip:
*Cell Phone: <input type="checkbox"/> Text Opt-in†	Home Phone:	Other Phone:	
*Email Address:		If Minor, Parent/Caregiver/Guardian Name (Last, First):	
*Do you have prescription drug coverage?	*Do you have commercial insurance?	*Please check any of the programs you are you eligible for: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Tricare	
*Number of Dependents:		*Annual Household Income (Patient/Guardian may be required to show proof of income):	

By signing below, I affirm and acknowledge that:

- Completing this form does not guarantee I will qualify for benefits of the PAP;
- I allow kaléo, and the companies working with it to use this registration information to administer any PAP benefits, and contact me about the PAP;
- kaléo may verify the accuracy of the information on this form;
- Any medicines received through the PAP shall not be sold, traded, bartered or transferred;
- The PAP is not insurance;
- kaléo reserves the right to change or discontinue the PAP at any time; and
- Any PAP benefits are not contingent on any future purchase.
- The information I have provided on this form is complete and accurate.

If I receive medicine through the PAP, I also affirm and acknowledge that:

- I will immediately notify kaléo of any change in my financial status and/or insurance coverage changes by calling 502-213-7601;
- I will not seek reimbursement of any type from my insurance provider for any costs of the medications received; and
- I will notify my insurance provider of the receipt of the medicines.


†I authorize kaléo and its partners to send me text messages about my AUVI-Q prescription order. Standard message and data rates may apply. To opt out, call (844) 357-3968.

If I refuse to sign below, I acknowledge that I will not be considered for any benefits of the PAP, but this will not affect my ability to obtain medical treatment, seek payment for medical treatment, or affect my insurance coverage or eligibility.

Patient's Signature	Date of Signature
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2. Prescriber and Prescription Information - To Be Completed by Prescriber

*Prescriber Name (Last, First):		*NPI:	
*Prescriber's Primary Specialty: <input type="checkbox"/> Allergy <input type="checkbox"/> Pediatrics <input type="checkbox"/> Other	Tax ID:	DEA:	
*Prescriber Address:		*City:	*State: *Zip:
*Office Contact Name (Last, First):	*Office Phone:	*Office Email:	

 <p>Drug: AUVI-Q® (epinephrine injection, USP) <input type="checkbox"/> 0.1 mg <input type="checkbox"/> 0.15 mg <input type="checkbox"/> 0.3 mg</p> <p>Dispense as Written: <input type="checkbox"/> Yes</p> <p>Quantity: <input type="checkbox"/> 1 Carton (2 auto-injectors and 1 trainer)</p>	<p>Diagnosis Code (ICD-10): _____</p> <p>History of, or at risk for, severe allergic reaction to: <input type="checkbox"/> Food <input type="checkbox"/> Insect Venom <input type="checkbox"/> Medications <input type="checkbox"/> Idiopathic</p> <p><input type="checkbox"/> Other: _____</p>
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Comments:

*I certify that this AUVI-Q® prescription 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 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	*Date of Signature
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3. PRESCRIBER TO FAX COMPLETED FORM TO (800) 943-1730