



# Kogenate<sup>®</sup> FS with BIO-SET<sup>®</sup> Free Trial Program

Case Number (For internal processing use only): \_\_\_\_\_

**FOR PATIENTS**

## PATIENT INSTRUCTIONS

1. Please note: Patients previously enrolled in the **Kogenate FS, antihemophilic factor (recombinant), with BIO-SET needleless reconstitution system**, Free Trial Program and those currently receiving **Kogenate FS** with BIO-SET therapy are not eligible to participate. In accordance with government statutes, patients covered in whole or in part by federal or state healthcare programs cannot participate.
2. Please fill out the Patient Information section of this form and bring it to your healthcare provider (HCP) to determine whether **Kogenate FS** with BIO-SET is right for you.
3. Ask your HCP to fill out the Prescriber and Prescription Information sections of this form.
4. **IMPORTANT: This form must be filled out completely and signed by your HCP or it will not be processed.**
5. Fax or mail the completed form to the fax number/address provided below.
6. For more information, please call 1-800-288-8374.
7. Your free product and practice kit will be sent to **you** at the address you specify below. Be sure to include your home telephone number with your address, so that shipment may be arranged.

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

Please circle: WORK CELL OTHER

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## PATIENT-PREFERRED SHIPPING ADDRESS for Kogenate FS with BIO-SET

Ship to: Home Address  Address below  (Product will be shipped by Accredo Health Group, Inc. and cannot be shipped to your HCP.)

Contact Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

Please circle: WORK CELL OTHER

Shipping Address: (Please include facility name, room #/department, if applicable) \_\_\_\_\_

Street: \_\_\_\_\_

Product cannot be shipped to PO boxes

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## PATIENT PERMISSION

Important: Your answers to the following questions do **not** exclude or disqualify you from participation in the **Kogenate FS** with BIO-SET Free Trial Program.

1. Would you allow a representative to contact you for a follow-up survey about your experience with **Kogenate FS** with BIO-SET? Yes  No
2. Would you like to be contacted about programs concerning **Kogenate FS** with BIO-SET? Yes  No
3. Would you like to be contacted electronically about product updates or product offerings from Bayer? Yes  No

E-mail Address: \_\_\_\_\_

## FREE TRIAL PROGRAM ENROLLMENT FORM RETURN INSTRUCTIONS

Once the patient and prescriber sections have been completed, please mail or fax the entire form for the **Kogenate FS** with BIO-SET Free Trial Program to:

### Kogenate FS with BIO-SET Free Trial Program

PO Box 230133

Centreville, VA 20120

Fax: 1-800-359-4699

**Important: Enrollment requests cannot be processed unless all information is filled out completely and the form is signed by the prescribing HCP. Enrollment requests cannot be processed unless the patient has received BIO-SET training. Participation in the Kogenate FS with BIO-SET Free Trial Program is not contingent on future treatment purchases.**

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# Kogenate® FS with BIO-SET® Free Trial Program

Patient Name: \_\_\_\_\_

**FOR PRESCRIBERS**

**IMPORTANT: In order to receive the free sample doses of Kogenate FS, antihemophilic factor (recombinant), with BIO-SET needleless reconstitution system, your patient must be trained on how to use the BIO-SET system.**

## PRESCRIBER VERIFICATION OF PATIENT TRAINING ON KOGENATE FS WITH BIO-SET

1. Has the patient received training on proper reconstitution and administration of **Kogenate FS** with BIO-SET? Yes  No
2. If the patient has not received training and you or your office needs training materials, please call 1-800-288-8374 to order a **Kogenate FS** with BIO-SET Practice Kit.
3. Once the patient has been trained on proper reconstitution and administration using **Kogenate FS** with BIO-SET, please sign and date here:

Prescriber's Signature: \_\_\_\_\_ Date of Training: \_\_\_\_\_

**Patient training on BIO-SET is essential because it will help make the patient more comfortable and confident with the system.**

## PRESCRIBER INSTRUCTIONS

1. Please fill out this section of the enrollment form completely, including verification of patient training on BIO-SET and the Prescriber and Prescription Information.
2. Patients are eligible for up to 6 free samples/doses of **Kogenate FS** with BIO-SET through the **Kogenate FS** with BIO-SET Free Trial Program.  
Total factor VIII product will not exceed 20,000 IU.
3. This prescription will be filled and shipped to the address specified by the patient on the reverse side of this form. Product cannot be shipped to PO boxes.
4. The patient must be trained on how to use BIO-SET before receiving the free product trial of **Kogenate FS** with BIO-SET.  
Please include the training date and authorize with your signature.
5. Sign and date the Prescriber Authorization and Release.
6. Fax both sides of the completed form to 1-800-359-4699.
7. For more information, please call 1-800-288-8374.

## PRESCRIPTION INFORMATION

Diagnosis: 286.0 Congenital Factor VIII disorder

Patient weight: \_\_\_\_\_ kg \_\_\_\_\_ lb Patient FVIII: \_\_\_\_\_% Target FVIII activity level desired: \_\_\_\_\_%

Total **Kogenate FS** IU required for 1 dose: \_\_\_\_\_

(**Kogenate FS** vial potency will be determined by the fulfilling pharmacy. Patient will receive enough vials to equal 6 sample doses, not to exceed 20,000 IU total.)

### Special Instructions:

Authorized refills = zero. *The patient must obtain a refill prescription for **Kogenate FS** with BIO-SET for future use.*

## PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_

Facility Name/Office Contact: \_\_\_\_\_

License # (required by law): \_\_\_\_\_ DEA #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## PRESCRIBER AUTHORIZATION AND RELEASE

By signing below, I certify that:

- (a) The above therapy is medically necessary;
- (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) to Bayer's **Kogenate FS** with BIO-SET Free Trial Program, managed by Parexel, and the contracted dispensing pharmacy or other contractors for the purpose of assisting in initiating or continuing therapy, reporting data to Bayer and Parexel, and/or the evaluation of the patient's eligibility for Bayer's **Kogenate FS** with BIO-SET Free Trial Program;
- (c) I appoint Parexel as my agent solely to convey, on my behalf to the pharmacy chosen by the above-named patient, the prescription described herein;
- (d) I agree that I will not resell or bill any third party, including any federal and state healthcare programs, for any product provided through this trial prescription program;
- (e) I understand that patients cannot participate in this program if they are covered in whole or in part by any federal or state healthcare programs in accordance with government statutes;
- (f) I certify that this patient is not currently receiving therapy with **Kogenate FS** with BIO-SET.

Prescriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

For important safety and use information, please see the full Prescribing Information at [www.kogenatefs.com/prescribing-information.jsp](http://www.kogenatefs.com/prescribing-information.jsp).



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**Kogenate FS**  
antihemophilic factor  
(recombinant)  
with BIO-SET®  
needleless reconstitution system

**Real Life...Real Protection**