KINIKSA oneconnect™
support made simple.

Instructions for Healthcare Providers

To prescribe ARCALYST® (rilonacept), please follow these steps:

1. **Have your patient read the Patient Consent Information and sign the 3 signature fields**
   Give your patient a copy of the Patient Consent Information page.
2. **Complete the Enrollment Form**
   Fill out all required fields of the Enrollment Form. Incomplete fields may delay the start of treatment. **Provide a copy of the front and back of the patient's medical and prescription insurance cards.**
3. **Fax Enrollment Form to (781) 609-7826**

Following enrollment:

- A Patient Access Lead with Kiniksa One Connect™ will contact your patient to discuss the next steps in getting their ARCALYST prescription filled
- The specialty pharmacy will coordinate delivery of the prescription to the address provided in Section 1 of the Enrollment Form

If you have any questions, call Kiniksa One Connect at 1-833-KINIKSA (1-833-546-4572).
To learn more about ARCALYST, visit https://www.arcalyst.com/HCP.

Instructions for Patients

To get started on ARCALYST, please follow these steps:

1. **Read the Patient Consent Information and sign the 3 signature fields**
2. **Your healthcare provider will fill out the Enrollment Form**

Following enrollment:

- A Patient Access Lead with Kiniksa One Connect will contact you to discuss the next steps in getting your ARCALYST prescription filled (these calls may come from an 833 number, "unknown number," or "no caller ID")
- The specialty pharmacy will coordinate delivery of the prescription to the address provided in Section 1 of the Enrollment Form

If you have any questions, call Kiniksa One Connect at 1-833-KINIKSA (1-833-546-4572).
To learn more about ARCALYST, visit https://www.arcalyst.com/HCP.

For details about how we collect and use personal information, your privacy rights, and specific notices for California residents, please visit: https://www.kiniksa.com/privacy-policy/.

PATIENT CONSENT INFORMATION

Please read the following, then complete and sign the areas indicated below.

I understand that Kiniksa One Connect ("the Program") is a prescription assistance and patient support service offered by Kiniksa Pharmaceuticals ("Kiniksa") to help eligible patients who have been prescribed a Kiniksa therapy to obtain financial assistance and access other patient support programs and services provided by the Program.

By signing below, I authorize my healthcare providers and staff (e.g., physicians, pharmacies) and my insurance company to disclose in electronic or other form, personal health information about me, including information related to my medical condition and any treatment, my health insurance coverage, and my address, email address, and telephone number (collectively, my "PHI") to Kiniksa, its affiliates, agents, contractors and representatives, including its commercial and field-based teams, and the Program so that Kiniksa may review, use and disclose the PHI and information on this form for purposes of: (1) verifying, investigating, assisting with, and coordinating my coverage for the therapy with my healthcare provider or health insurers; (2) assessing my eligibility for co-pay assistance or free drug or referring me to other programs and sources of funding and financial support; (3) coordinating delivery of the therapy to me or my healthcare provider; (4) providing education, information on Kiniksa products, and support services to me related to the therapy; (5) gathering feedback on my therapy and/or disease state; (6) contacting me by mail, email, phone or text for any of the above purposes; and (7) creating information that does not identify me personally for use other than for the legitimate purposes as set forth in this authorization. I also authorize Kiniksa and my healthcare providers and my insurance company to use my PHI to communicate with me about Kiniksa products and services. I authorize my pharmacy and Kiniksa contractors to receive remuneration from Kiniksa for disclosing or using my PHI and/or for providing support services as outlined in this authorization. I understand that once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Kiniksa to others, but I also understand that Kiniksa will make reasonable efforts to keep my PHI private and to disclose it only for purposes set forth in this authorization.

I understand that I do not have to sign this authorization to obtain healthcare treatment or benefits; however, in order to receive the services and communications described above, I must sign the authorization. I understand that I may cancel my authorization at any time by contacting Kiniksa by fax at (781) 609-7826, or by mail at Kiniksa One Connect, 100 Hayden Avenue, Lexington, MA 02421. My cancellation of this authorization will be effective for Kiniksa upon receipt, and will be effective for each of my healthcare providers and insurance companies when they are notified of it, but the cancellation will not affect prior uses or disclosures of PHI.

I understand that I have a right to receive a copy of this authorization.

This authorization expires one (1) year after the date I sign it as shown below, or such earlier date as may be required by the state in which I reside, unless I cancel it before then.

PATIENT CONSENT*

I have read, understand, and agree to all the PATIENT CONSENT INFORMATION and verify that the information I have provided in this authorization is complete and accurate. I understand that Kiniksa reserves the right at any time and without notice to modify or discontinue Kiniksa One Connect (including any assistance provided to me) and the related eligibility criteria. I give Kiniksa One Connect permission to call me regarding my enrollment.

*Printed Name of Patient, Legal Guardian or Personal Representative:

*Relationship to Patient:

***Signature of Patient, Legal Guardian or Personal Representative:** ***Date:**

I consent to Kiniksa One Connect verifying, investigating, assisting with, and coordinating my coverage for the therapy with my healthcare provider or health insurers.

*Printed Name of Patient, Legal Guardian or Personal Representative:

*Relationship to Patient:

***Signature of Patient, Legal Guardian or Personal Representative:** ***Date:**

I consent to Kiniksa One Connect contacting me by mail, email, phone or text for any of the above purposes.

*Printed Name of Patient, Legal Guardian or Personal Representative:

*Relationship to Patient:

***Signature of Patient, Legal Guardian or Personal Representative:** ***Date:**

☐ By checking this box, I consent to participate in marketing surveys, and receive marketing communications and materials from Kiniksa via phone, mail, or email. I understand that I may opt out of receiving such messages at any time by calling 1-833-KINIKSA (1-833-546-4572) or emailing KiniksaOneConnect@kiniksa.com.

☐ By checking this box, I consent to receive recurring text messages from Kiniksa One Connect, including service updates and medication reminders, to the number I have provided. Message and data rates may apply. I am not required to consent or provide my consent as a condition of receiving any goods or services. I can text STOP to unsubscribe any time. For more details, please visit https://www.kiniksa.com/sms-policy/.

***Required information.**

ENROLLMENT FORM

KINIKSA oneconnect™ support made simple.

***Required information.**

1. PATIENT INFORMATION*

Clinical Trial Transition Patient: ☐ Y ☐ N

First Name: | MI: | Last Name: | Suffix: | Gender: ☐ M ☐ F

Home Address: | City/State: | ZIP:

Alt Address: | City/State: | ZIP:

Ship Treatment to: ☐ Home Address ☐ Alt Address

DOB: | Home Phone: | Mobile Phone: | Email:

Preferred Contact Method: ☐ Home Phone (OK to Leave Messages: ☐ Y ☐ N) ☐ Mobile Phone (OK to Leave Messages: ☐ Y ☐ N) ☐ Text ☐ Email

Best Time to Contact: ☐ Weekday Mornings ☐ Weekday Afternoons ☐ Weekday Evenings

Language: ☐ English ☐ Spanish ☐ Other

Alternate Contact First Name: | Last Name:

Relationship to Patient:

Phone: | Email: | OK to Leave Messages: ☐ Y ☐ N

2. INSURANCE INFORMATION* *Please provide a copy of the front and back of the patient's medical and prescription insurance cards.*

Is the patient enrolled in a government-funded health plan,† qualified health plan (QHP), or plan offered on a state or federal marketplace or exchange? ☐ Yes ☐ No ☐ Patient Does Not Have Health Insurance

†Such as Medicare, Medicare Part D, Medicaid, VA, DoD, TRICARE®.

Primary Insurance: | ID #: | Group #: | Phone #:

Policy Holder: | Relationship to Patient:

Pharmacy Insurance: | ID #: | Group #: | Phone #:

Policy Holder: | Relationship to Patient:

RxBIN: | RxPCN:

3. PRESCRIBER INFORMATION*

First Name: | Last Name: | Specialty:

Address: | City/State: | ZIP:

Prescriber Email Address:

NPI #: | License # (and state):

Tax ID #:

4. PRACTICE CONTACT INFORMATION*

Practice Name: | Contact Name:

Address: | City/State: | ZIP:

Contact Phone: | Contact Fax: | Contact Email:

5. PHARMACY INFORMATION* *Please select only one of the network pharmacies listed below or No Preference.*

☐ AcariaHealth	☐ Accredo	☐ AllianceRx (Walgreens)	☐ CVS Specialty	☐ Optum	☐ No Preference

*Required information.

KINIKSA oneconnect™ support made simple.

6. PRESCRIPTION FOR ARCALYST® (rilonacept) injectable sterile powder for reconstitution, 220 mg/vial*

Patient First Name: _____ **Last Name:** _____ **DOB:** _____

Home Address: _____ **City/State:** _____ **ZIP:** _____

☐ **Once Weekly Dosing for Patients ≥18 Years of Age: for Pericarditis or Cryopyrin-Associated Periodic Syndromes (CAPS)**

Loading Dose (320 mg) x 1 dose administered subcutaneously on the first week in two 3-mL syringes (160 mg each) on the same day at different injection sites

To be administered at: ☐ Practice ☐ Home Refills: 0

Maintenance Dose (160 mg) administered subcutaneously in one 3-mL syringe once weekly

To be administered at: ☐ Practice ☐ Home Refills: _____ Quantity: 30-day supply

☐ **Once Weekly Dosing for Patients 12 to 17 Years of Age: for Pericarditis or Cryopyrin-Associated Periodic Syndromes (CAPS)**

Patient Weight: _____ lb _____ kg Date Weight Obtained (mm/dd/yyyy): _____

Loading Dose (4.4 mg/kg up to a maximum of 320 mg) x 1 dose administered subcutaneously on the first week in one or two 3-mL syringes (160 mg each) on the same day at different injection sites

To be administered at: ☐ Practice ☐ Home Refills: 0

Maintenance Dose (2.2 mg/kg up to a maximum of 160 mg) administered subcutaneously in one 3-mL syringe once weekly

To be administered at: ☐ Practice ☐ Home Refills: _____ Quantity: 30-day supply

☐ **Once Weekly Dosing for Adult and Pediatric Patients Weighing at Least 10 kg: for Deficiency of IL-1 Receptor Antagonist (DIRA)**

Patient Weight: _____ lb _____ kg Date Weight Obtained (mm/dd/yyyy): _____

4.4 mg/kg up to a maximum of 320 mg administered subcutaneously in two 3-mL syringes once weekly

To be administered at: ☐ Practice ☐ Home Refills: _____ Quantity: 30-day supply

☐ **Vial of Preservative-Free Sterile Water for Injection** Refills: _____ Quantity: 4

Ancillary Supplies

☐ I request inclusion of the ancillary supplies listed below, which are needed to administer ARCALYST. The ancillary supplies will be sent to patients with their ARCALYST treatment **and are included in the cost**. Certain state laws require the physician to include a prescription for ancillary materials. The label for ARCALYST requires the following ancillary materials:

- 10 - Sterile 3-milliliter (mL) disposable syringes with markings at each 0.1 mL
- 10 - Sterile disposable needles (26 gauge, ½ inch) with needle covers
- 10 - Sterile blunt beveled needles (18 gauge, 1 inch or 1.5 inches) with needle covers
- 20 - Alcohol wipes
- 8 - 2x2 gauze pad
- 1 - Puncture-resistant container for disposal of used needles, syringes, and vials

***Concurrent Medications:** _____

***Allergies:** ☐ No Known Drug Allergies ☐ Other: _____

Injection Training for Patient Will Be Conducted by:

☐ Prescriber/Practice (In-Office)

☐ Kiniksa One Connect: ☐ Virtual ☐ Hybrid (Virtual and In-Person)

7. DIAGNOSIS*

☐ Pericarditis	☐ Cryopyrin-Associated Periodic Syndromes
☐ Deficiency of IL-1 Receptor Antagonist	☐ Other: _____

8. PRESCRIBER CERTIFICATION*

Please manually sign and date below rubber stamps. Signature by other office personnel or computer-generated images are not allowed.

Prescriber Name (Print): _____

_____ _____

Prescriber Signature (No Stamps) Date -OR- Prescriber Signature (No Stamps) Date

DISPENSE AS WRITTEN SUBSTITUTIONS PERMITTED

By signing above, I certify that (1) the information contained in this application is current, complete and accurate to the best of my knowledge; (2) the therapy is medically necessary and in the best interest of the patient identified above; (3) I have obtained and provided any consent required under federal and state law for the release and use of the patient's personal health information including diagnosis, treatment, medical and insurance contained on this form to Kiniksa Pharmaceuticals ("Kiniksa") and its agents, including commercial and field-based teams, for purposes of benefits verification and coordination of dispensing therapy, or to otherwise assist the patient to initiate or continue the prescribed therapy and/or to evaluate the patient's eligibility for the QuickStart Program, Patient Assistance Program or other programs for ARCALYST; and (4) I will not seek payment from any payer, patient or other source for free product provided directly to the patient.

I understand that I am under no obligation to prescribe any Kiniksa therapies, to participate in Kiniksa One Connect, and that I have not received, nor will I receive, any benefit from Kiniksa for prescribing a Kiniksa therapy. I certify that I am a legal resident of the United States (and U.S. territories).

I authorize Kiniksa and its agents to convey the above prescription by any means allowed under applicable law to the dispensing pharmacy.
Special note: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.