ultragenyx pharmaceutical | UltraCare™

UPON ENROLLMENT, AN ULTRACARE GUIDE WILL:

- Partner with and remain dedicated to your patient throughout the treatment journey
- Contact the patient or caregiver to review insurance coverage and support programs
- Assess the patient's eligibility for available financial assistance programs

GETTING STARTED: STEPS FOR SUCCESSFUL ENROLLMENT IN ULTRACARE

Below are the most critical steps for ensuring complete and timely enrollment in UltraCare so your patient can benefit fully from the program's suite of support services.

1 SELECT PREFERRED PATIENT COMMUNICATION METHOD

- Ask your patient and/or caregiver about how they will prefer to communicate with their UltraCare Guide and the best time to contact them

2 VERIFY THE PATIENT'S INSURANCE

- Provide a copy of the front and back of all of the patient's **medical and prescription** insurance cards
- Indicate if the patient does not have health insurance (medical and pharmacy)

3 OBTAIN PATIENT CONSENT[a]

- The patient signature is required to allow third parties to share protected health information with Ultragenyx and to facilitate:
  - Benefits investigation
  - Prior authorization
  - Specialty pharmacy provider prescription transfer
  - Home infusion agency
  - Additional services provided by UltraCare, including insurance coverage, financial assistance, and patient support programs

4 SELECT SITE OF CARE (SOC)

- Choose your preferred SOC for the administration of the medication:
  - Home injection
  - Office administration
  - Outpatient hospital setting

5 SPECIFY PRESCRIPTION FOR CRYSVITA® (burosumab-twza)

- Patient weight (kg) × recommended starting dose = total initial dose (rounded to nearest 10 mg)
  - Pediatric: Recommended starting dose is 0.8 mg/kg of body weight (round to nearest 10 mg and max dose is 90 mg) every 2 weeks
  - Adult: Recommended starting dose is 1 mg/kg of body weight (round to the nearest 10 mg and max dose is 90 mg) every 4 weeks
- Ensure the physician provides a wet signature and date, which are necessary to process the prescription

6 FILL OUT ADDITIONAL INFORMATION

- Allow patient to choose whether or not to receive additional information from Ultragenyx

7 DETERMINE DISCLOSURE PERMISSIONS

- Indicate if the patient would like to allow their information to be shared with other individuals

[a]If the patient wants to opt out of the patient consent section, inform the UltraCare team verbally on the phone or in writing to the address on the next page.

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Toll-free Line: 888-756-8657 | **Fax:** 415-723-7474 | http://www.ultracaresupport.com
Email: UltraCare@ultragenyx.com | **Address:** 5000 Marina Boulevard, Brisbane, CA 94005

Patient Start Form

1 PATIENT INFORMATION: Be sure to choose your preferred contact method

First Name _____ Middle Initial _____
Last Name _____
Gender ☐ Female ☐ Male
DOB (MM/DD/YYYY) _____
Last 4 Digits of Social Security # _____
Street Address _____
City _____
State _____ ZIP _____
Home Phone (___) _____ Work Phone (___) _____
Mobile Phone (___) _____ Best Time to Contact _____
Preferred Method of Contact ☐ Home ☐ Work ☐ Mobile ☐ Text ☐ Email
Preferred Language _____
Email _____
Caregiver Name (First and Last) _____
Relationship to Patient _____
Caregiver Phone (___) _____

2 PRESCRIBER INFORMATION:

First Name _____
Last Name _____
Street Address _____
City _____
State _____ ZIP _____
Office Phone (___) _____ Fax (___) _____
Office Email _____
Office Contact Name/Title _____
Office Contact Phone (___) _____
State License # _____ NPI # _____

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.

3 CRYSVITA PRESCRIPTION INFORMATION: Select ICD-10-CM code and type of prescription

Pediatric XLH: Starting dose regimen is 0.8 mg/kg of body weight rounded to the nearest 10 mg, administered every 2 weeks. The minimum starting dose is 10 mg up to a maximum dose of 90 mg.

Adult XLH: Starting dose regimen is 1 mg/kg of body weight rounded to the nearest 10 mg up to a maximum dose of 90 mg, administered every 4 weeks.

How Supplied: 10 mg/mL single-dose vial, 20 mg/mL single-dose vial, 30 mg/mL single-dose vial.

Subcutaneous injection only.

☐ **E83.31 (familial hypophosphatemia)** ☐ **E83.39 (other disorders of phosphorus metabolism)** ☐ **Other** _____

CRYSVITA Prescription	Date Weight Taken	Patient Weight (in kg)	Initial Dose Prescribed	Total Calculated Dose (Round to the nearest 10 mg and max dose is 90 mg)	Frequency	Days Supply (Limit: 28 days)	Refills
		x	☐ 0.8 mg/kg (Pediatric) ☐ 1 mg/kg (Adult)		☐ Every 2 weeks (Pediatric) ☐ Every 4 weeks (Adult)		

☐ **Prescriber:** Please check here to authorize ancillary supplies, such as needles and syringes, as needed to administer the therapy.

Vial Size and Quantity
☐ 10 mg/mL x _____ ☐ 20 mg/mL x _____ ☐ 30 mg/mL x _____ ☐ Concurrent Medications (Attached List)
Special Instructions _____
Special Precautions (eg, Allergies) _____

Prescriber Signature _____ (No Stamps) Dispense as Written Date _____

☐ Fast Start Prescription (for AllCarePlus Pharmacy Only)

Vial Size and Quantity
☐ 10 mg/mL x _____ ☐ 20 mg/mL x _____ ☐ 30 mg/mL x _____ ☐ Concurrent Medications (Attached List)
Special Instructions _____
Special Precautions (eg, Allergies) _____

Prescriber Signature _____ (No Stamps) Dispense as Written Date _____

Fast Start: For all naive to commercial therapy, patient and product must be sent to the healthcare provider for administration at office, and cost will not be passed along to patient.

Desired Site of Care:
☐ Home Injection (see patient home address)
☐ Physician Office (see provider office address)
☐ Alternate Medical Facility (provide facility name and address)
☐ Facility to Home (first dose at facility; remainder at home)
Facility Name/Address _____
☐ RN visit to provide education related to therapy, disease state, and nurse administration of CRYSVITA to include dosing and titration as per prescriber order.

I authorize Ultragenyx to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc.

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Patient Start Form

INSURANCE INFORMATION: Be sure to provide copies of patient's MEDICAL and PRESCRIPTION cards

☐ Patient does not have health insurance

☐ Provide copies of all medical and prescription cards—front and back (primary and secondary, supplemental coverage) [If copies provided, no need to populate this section]

PRIMARY INSURANCE INFORMATION

Insurance Name _____ Insurance Phone (____) _____
Policyholder Name _____ Relationship to Patient _____
Group ID _____ Employer Name _____
Member ID _____

SECONDARY INSURANCE INFORMATION

4

Insurance Name _____ Insurance Phone (____) _____
Policyholder Name _____ Relationship to Patient _____
Group ID _____ Employer Name _____
Member ID _____

PRESCRIPTION CARD INFORMATION

Prescription Card Name _____ Prescription Phone (____) _____
Policyholder Name _____ Relationship to Patient _____
Member ID _____ BIN # _____
PCN # _____

PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION (PHI) AND SIGNATURE

5

I authorize each of my physicians and pharmacists (including any specialty pharmacies and other health care providers), and each of my health insurers, to disclose my PHI, including but not limited to medical records, information related to my medical condition and treatment, financial information, lab values, insurance coverage information, my name, address, telephone number, and last 4 digits of Social Security number to Ultragenyx Pharmaceutical, Inc., and its agents, contractors, and assignees to use and disclose my PHI to enroll me in and contact me about UltraCare Patient Services, provide case management through telephone or electronic communications to assist with adherence to my medication regimen, and work with third parties to provide community resources and referrals. Third-party vendors, such as specialty pharmacies, may receive financial remuneration in exchange for data, product support services, reimbursement services, etc. This authorization expires one year from the date of execution, or one year after the date of my last prescription, whichever is later, unless a shorter period is required by state law. I understand I may refuse to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits, including my access to therapy, is not conditioned on my signing this authorization. I understand that revoking this authorization will not affect the ability to use and disclose PHI received prior to receipt of notification that I wish to discontinue my participation in the program. I understand I may revoke this authorization at any time verbally or by writing to the address listed at the top of this form. Once authorization has been revoked or expired, I understand my future PHI will not be disclosed. I understand that my PHI will not be used or disclosed for any other purposes, unless permitted by law, than for the purposes stated above. Information disclosed pursuant to this authorization or provided to a third-party may no longer be protected by federal privacy laws.

Patient Signature_____ **Date** _____

Parent/Guardian Signature (if patient is a minor)_____ **Date** _____

ADDITIONAL INFORMATION

6

☐ I would like to receive Ultragenyx marketing materials for educational purposes.
☐ I would like to learn more about UltraCare patient services. Please call me to review these services.
☐ I would like to be considered for future Ultragenyx marketing research projects. Please contact me to discuss the detail of the marketing research projects.

Patient Signature_____ **Date** _____

Parent/Guardian Signature (if patient is a minor)_____ **Date** _____

DISCLOSURE TO GRANT PERMISSION TO DISCUSS ULTRACARE PATIENT SERVICES INFORMATION

7

☐ I give permission to the Patient Support team to disclose my Patient case information to the following parties:

Name _____
Relationship to Patient _____
☐ Primary ☐ Secondary ☐ Tertiary
Street Address _____
City _____
State _____
ZIP _____
Phone (_____) _____

Name _____
Relationship to Patient _____
☐ Primary ☐ Secondary ☐ Tertiary
Street Address _____
City _____
State _____
ZIP _____
Phone (_____) _____

Notes: _____