ultragenyx pharmaceutical

UltraCare

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

Please complete both pages to ensure successful enrollment.

1 PRESCRIBER INFORMATION:

First Name _____ Last Name _____

Office/Clinic/Institution Name _____ State License # _____ NPI # _____

Street Address _____ City _____ State _____ ZIP _____

Office Phone (____) _____ Fax (____) _____ Office Email _____

Office Contact Name/Title _____ Office Contact Phone (____) _____

Office Contact Email _____

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

First Name _____ Middle Initial _____ Last Name _____

☐ Female ☐ Male DOB (MM/DD/YYYY) _____ Last 4 Digits of SSN _____

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 (____) _____

Caregiver Email _____ ☐ OK to leave message with caregiver

3 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)

4 ADDITIONAL INFORMATION

☐ I would like to receive information about Ultragenyx educational events, newsletters, and resources

☐ Please contact me so that I can learn more about UltraCare patient services

☐ Please consider me for Ultragenyx market research projects and contact me with details

☐ I am interested in information about X-linked hypophosphatemia (XLH) or tumor-induced osteomalacia (TIO)

Patient Signature _____ **Date** _____

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

5 DISCLOSURE TO GRANT PERMISSION TO DISCUSS ULTRACARE PATIENT SERVICES INFORMATION

☐ 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 (_____) _____

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

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

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

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Patient Start Form

Patient Name _____ DOB (MM/DD/YYYY)_____

CRYSVITA® (burosumab-twza) PRESCRIPTION INFORMATION: Select ICD-10-CM code below and type of prescription

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- ☐ **XLH: E83.31 (familial hypophosphatemia)**
- ☐ **TIO: M83.8 (other adult osteomalacia)**
- ☐ **E83.39 (other disorders of phosphorus metabolism)**
- ☐ **Other** _____

Subcutaneous injection only and should be administered by a health care provider. How Supplied: 10 mg/mL single-dose vial, 20 mg/mL single-dose vial, 30 mg/mL single-dose vial.

X-LINKED HYPOPHOSPHATEMIA (XLH) DOSING REGIMENS:

Pediatric XLH (6 months to less than 18 years of age):

- For patients who weigh less than 10 kg, starting dose regimen is 1 mg/kg of body weight rounded to the nearest 1 mg, administered every 2 weeks
- For patients who weigh more than 10 kg, 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

Body Weight (kg)	10–14	15–18	19–31	32–43	44–56	57–68	69–80	81–93	94–105	106 and greater
Starting Dose (mg)	10	10	20	30	40	50	60	70	80	90
First Dose Increase to (mg)	15	20	30	40	60	70	90	90	90	90
Second Dose Increase to (mg)	20	30	40	60	80	90	90	90	90	90

Adult XLH (18 years of age and older): 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.

TUMOR-INDUCED OSTEOMALACIA (TIO) ASSOCIATED WITH PHOSPHATURIC MESENCHYMAL TUMORS DOSING REGIMENS:

Pediatric TIO (2 years to less than 18 years of age): Starting dose is 0.4 mg/kg of body weight rounded to the nearest 10 mg every 2 weeks. Dose may be increased up to 2 mg/kg not to exceed 180 mg, administered every 2 weeks.

Body Weight (kg)	10–14	15–18	19–31	32–43	44–56	57–68	69–80	81–93	94–105	106 and greater
Starting Dose (mg)	5	5	10	10	20	20	30	30	40	40
First Dose Increase to (mg)	10	10	20	30	40	50	60	70	80	90
Second Dose Increase to (mg)	15	20	25	40	50	70	80	100	110	130
Third Dose Increase to (mg)	20	25	30	50	70	90	100	120	140	160

The table shows a dose increase up to 1.5 mg/kg. Further dose increases to a maximum of 2 mg/kg not to exceed 180 mg, administered every 2 weeks, should be calculated by the physician.

Adult TIO (18 years of age and older): Starting dose is 0.5 mg/kg every 4 weeks. Dose may be increased up to 2 mg/kg not to exceed 180 mg, administered every 2 weeks.

	Starting Dose	First Dose Increase†	Second Dose Increase†	Third Dose Increase†	Fourth Dose Increase	Fifth Dose Increase (maximum dose)
If serum phosphorus 2 weeks post-dose adjustment is below lower limit of normal*	0.5 mg/kg every 4 weeks	Increase to 1 mg/kg every 4 weeks OR 0.5 mg/kg every 2 weeks	Increase to 1.5 mg/kg every 4 weeks‡ OR 0.75 mg/kg every 2 weeks	Increase to 2 mg/kg every 4 weeks‡ OR 1 mg/kg every 2 weeks	Increase to 1.5 mg/kg not to exceed 180 mg every 2 weeks	Increase to 2 mg/kg not to exceed 180 mg every 2 weeks

*Rounded to the nearest 10 mg. Do not adjust CRYSVITA more frequently than every 4 weeks.
†For those individuals not reaching a serum phosphorus greater than the lower limit of the normal range, physicians may consider dividing total dose administered every 4 weeks and administering every 2 weeks.
‡In patients with high body weight, if the calculated dose is greater than 180 mg every 4 weeks, move to a divided dose of every 2 weeks.

CRYSVITA Prescription	Date Weight Taken	Patient Weight (in kg)	Initial Dose Prescribed	Total Calculated Dose	Frequency	Days Supply	Refills
☐ XLH ☐ TIO		x	☐ 0.4 mg/kg (Pediatric TIO) ☐ 0.5 mg/kg (Adult TIO) ☐ 0.8 mg/kg (Pediatric XLH) ☐ 1 mg/kg (Adult XLH or Pediatric XLH less than 10 kg)		☐ Every 2 weeks SQ ☐ Every 4 weeks SQ		

☐ Pharmacy is to dispense supplies needed for administration ☐ No Known Drug Allergies (NKDA)

Vial Size and Quantity

☐ Pharmacist to select strengths used based on dose unless otherwise stated Special Instructions _____

☐ Concurrent Medications (Attached List) Special Precautions (eg, Allergies) _____

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Prescriber Signature (no stamps) _____ Dispense as Written Date _____

Prescriber Signature (no stamps) _____ Substitution Permitted Date _____

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.

Desired Site of Care:

☐ Home Injection (see patient home address) including RN visit to provide education related to therapy, disease state, and nurse administration of CRYSVITA

☐ 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 _____

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. Transmission of this form shall be via fax or mail; verbal transmission does not constitute a valid prescription. The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc.