

- Partner with and remain dedicated to your patient throughout the treatment journey
- Contact the patient or caregiver to review insurance coverage and support programs

GETTING STARTED: STEPS FOR SUCCESSFUL ENROLMENT IN ULTRACARE

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

1 OBTAIN PATIENT CONSENT^a
The patient signature or verbal consent is required to allow third parties to share protected health information with Ultragenyx

2 SELECT PREFERRED PATIENT COMMUNICATION METHOD
Ask your patient and/or caregiver about how they will prefer to communicate with their UltraCare Case Manager and the best time to contact them

3 PRESCRIBER INFORMATION
Provide contact details

4 SPECIFY PRESCRIPTION FOR ^{Pr} CRYSVITA™ (burosumab injection)
Ensure the physician provides a wet signature and date, which are necessary to process the prescription

^aIf the patient wants to opt out of the patient consent section, inform the UltraCare team verbally on the phone or in writing to the email address below.

PATIENT CONSENT TO COLLECT, USE AND SHARE PERSONAL INFORMATION (PI) AND SIGNATURE

I understand that the UltraCare Program ("Program") is sponsored by Ultragenyx Pharmaceutical, Inc. ("Ultragenyx") and administered by Innomar on behalf of Ultragenyx. I understand that other service providers may be appointed by Ultragenyx to administer the Program from time to time. 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 PI, including but not limited to medical records, information related to my medical condition and treatment, financial, lab values, insurance coverage information, my name, address and telephone number to Ultragenyx and its agents, contractors, and assignees who will collect, use and disclose my PI to manage and administer the Program, including 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. I also authorize the collection, use and disclosure of information provided directly by me to the Program for legal obligations to report adverse drug events to health authorities and to monitor product complaints. I understand that Ultragenyx may contact me or my health care providers for additional information to fulfill its reporting obligations. I also understand that my PI may be combined with the information of others who participate in the Program in order to generate aggregated data to improve the Program, to design and implement other patient programs and for research purposes including the identification of trends such as product utilization, adherence or outcomes.

I understand that Ultragenyx and its agents, contractors and assignees may store or process my PI outside of Canada (including in the United States), where local laws may require the disclosure of PI to government authorities under circumstances that are different than those that apply in Canada. I understand I may refuse to sign this consent, in which case I cannot be enrolled in the Program and understand that my treatment and eligibility for health benefits, including my access to therapy, will not be otherwise conditioned on my signing this consent. I understand that revoking this consent will not affect the ability to use and disclose PI received prior to receipt of notification that I wish to discontinue my participation in the Program. I understand I may revoke this consent at any time verbally or by writing to the address listed at the top of this form. Once consent has been revoked, I understand no additional PI will be collected. I understand that my PI will not be used or disclosed for any purposes, unless permitted by law, other than the purposes stated herein.

I understand that I may contact the Program at any time to update or access my PI, modify, express a privacy-related concern, or inquire about the privacy practices of the Program.

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

IMPORTANT: If health care provider is unable to obtain written consent from patient, please document when patient verbal consent was obtained. This will allow the program to continue with processing this enrolment. Written consent will be obtained by the program. Verbal consent should be obtained by a health care provider.

Patient consented verbally Date (DD/MM/YYYY) _____

Patient consent obtained by: Name (Last, First) _____ Title: MD RN Other (specify) _____ Signature _____

By providing my email address, I agree to receive, electronically, communications from Innomar acting on behalf of Ultragenyx Pharmaceutical, Inc. containing information and updates relating to my enrolment in the UltraCare Program. I understand that I may withdraw my consent to such communications at any time by providing notice to Innomar Strategies, Inc., c/o UltraCare Program, 2600 Alfred Nobel Blvd., Ville Saint-Laurent, QC H4S 0A9, or via email at ultracare@innomar-strategies.com.

Patient Enrolment Form

PATIENT INFORMATION: Be sure to choose your preferred contact method

2 First, Middle, Last Name _____
 Gender Female Male DOB (DD/MM/YYYY) _____
 Street Address _____
 City _____
 Province _____ Postal Code _____
 Home Phone (____) _____ Work Phone (____) _____
 Mobile Phone (____) _____ Best Time to Contact _____
 Preferred Method of Contact: Home Work Mobile Email
 Preferred Language: English French Other _____
 Email _____
 Caregiver Name (First and Last) _____
 Relationship to Patient _____ Caregiver Phone (____) _____

PRESCRIBER INFORMATION:

3 First Name _____
 Last Name _____
 Street Address _____
 City _____
 Province _____ Postal Code _____
 Office Phone (____) _____
 Fax (____) _____
 Office Email _____
 Office Contact Name/Title _____
 Office Contact Phone (____) _____
 License # _____

CRYSVITA PRESCRIPTION INFORMATION:

Pediatric XLH (6 months to <1 year of age):

Starting dose regimen for a body weight ≥ 6 kg is 0.8 mg/kg of body weight, rounded down to the nearest 1 mg, administered every 2 weeks. The minimum starting dose is 5 mg.

Pediatric XLH (1 year to 18 years of age):

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.

Familial hypophosphatemia Positive *PHEX* variant test Other disorders of phosphorus metabolism Other _____

Date Weight Taken	Patient Weight (in kg)	Initial Dose Prescribed <input type="checkbox"/> 0.8 mg/kg (Pediatric) <input type="checkbox"/> 1 mg/kg (Adult)	Total Calculated Dose <input type="checkbox"/> Round down to the nearest 1 mg and min dose is 5 mg <input type="checkbox"/> Round to the nearest 10 mg and max dose is 90 mg	Frequency <input type="checkbox"/> Every 2 weeks (Pediatric) <input type="checkbox"/> Every 4 weeks (Adult)	Days Supply (Limit: 28 days)	Refills
		x				

Prescriber Signature _____ Date _____

Special Instructions _____

Special Precautions (eg, Allergies) _____

The prescriber assumes responsibility for monitoring lab values. The prescriber assumes responsibility for notifying UltraCare of any dosage changes, or suspension of therapy.