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 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

2 INSURANCE INFORMATION: Be sure to provide copies (front and back) 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)

☐ Patient demographic sheet provided

3 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** _____

4 GRANT PERMISSION FOR INFORMATION DISCLOSURE TO THIRD PARTY OTHER THAN PARENT/GUARDIAN OR ULTRACARE PATIENT SERVICES

☐ 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 (_____) _____

5 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 long-chain fatty acid oxidation disorders

Patient Signature_____ **Date** _____

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

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PATIENT NAME _____ DOB (MM/DD/YYYY): _____

PRESCRIBER INFORMATION:

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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 _____

DOJOLVI™ (triheptanoin) oral liquid PRESCRIPTION INFORMATION: Select ICD-10-CM code below and type of prescription

- ☐ **E71.30 (disorder of fatty-acid metabolism, unspecified)**
- ☐ **E71.310 (long chain/very long chain acyl CoA dehydrogenase deficiency)**
- ☐ **E71.318 (other disorders of fatty-acid oxidation)**
- ☐ **Other _____**
- ☐ **E71.31 (disorders of fatty-acid oxidation)**
- ☐ **E71.314 (muscle carnitine palmitoyltransferase deficiency)**
- ☐ **E71.39 (other disorders of fatty-acid metabolism)**

For ☐ ORAL or ☐ EXTERNAL FEEDING TUBE use only.
TUBE TYPE: _____ FEEDS: BOLUS _____ or CONTINUOUS _____

The recommended target daily dosage of DOJOLVI is up to 35% of the patient's total prescribed daily caloric intake (DCI), converted to mL. DOJOLVI should be thoroughly mixed with food or drink and taken by mouth or administered via a gastrostomy tube divided into at least 4 doses and administered at mealtimes or with snacks.

For patients not currently taking a Medium Chain Triglyceride (MCT) product
Initiate DOJOLVI at a total daily dosage of approximately 10% DCI divided into at least 4 times per day and increase to the recommended total daily dosage of up to 35% DCI over a period of 2 to 3 weeks.

For patients switching from an MCT formulation
Discontinue use of MCT products before starting DOJOLVI. Initiate DOJOLVI at the last tolerated dosage of MCT. Increase the total daily dosage by approximately 5% DCI every 2 to 3 days until the target dosage of up to 35% DCI or maximum tolerated dose is achieved.

The total daily dose (mL) of DOJOLVI is determined using the following calculation:
- Caloric value of DOJOLVI = 8.3 kcal/mL
- Round the total daily dosage to the nearest whole number
- Divide the total daily dosage into at least 4 approximately equal individual doses

$$\text{Total Daily Dose (\_\_\_\_mL)} = \frac{\text{Patients DCI (\_\_\_\_kcal) x Target \_\_\_\_ \% dose of DCI}}{8.3 \ \frac{\text{kcal}}{\text{mL}} \text{ of DOJOLVI}}$$

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☐ DOJOLVI Prescription (Titration)	Initial Total Daily Dose (mL) Rounded to Nearest Whole Number	÷ _____ Doses/Day = (at least 4)	Initial mL per Dose	Increase by _____ mL every _____ day(s) until reaching target _____ mL dose *Use the Prescription Directions field below to describe alternate desired dosing protocols*	Days Supply	Refills

Prescription Directions

_____

_____

☐ DOJOLVI Prescription (Maintenance)	Target Total Daily Dose (mL) Rounded to Nearest Whole Number	÷ _____ Doses/Day = (at least 4)	Days Supply	Refills

How Supplied: DOJOLVI (triheptanoin) oral liquid is supplied in glass bottles as follows: **500 mL bottle (NDC 69794-050-50)**

☐ No Known Drug Allergies (NKDA) ☐ Drug or Non-Drug Allergies _____ ☐ Concurrent Medications _____

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.

☐ A Clinical Engagement Liaison will engage my patient to confirm an understanding and educate on my prescription orders and disease management, or opt out by checking this box

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.