Mepsevii®
(vestronidase alfa-vjbk)
injection, for intravenous use
10 mg/5 mL (2 mg/mL)

UltraCare®

UPON ENROLLMENT, AN ULTRACARE GUIDE WILL:

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

STEPS TO SUCCESSFUL ENROLLMENT IN ULTRACARE

Below are the most critical steps for ensuring complete and timely enrollment so that your patients can fully benefit from the UltraCare Program:

1 GET STARTED

Select the preferred method of communication between the UltraCare Guide and the patient/caregiver

2 SELECT SITE OF CARE (SOC)

Choose the SOC for the administration of the medication:

- Home infusion with the home health nursing assistant
- Prescriber's office administration
- Outpatient hospital setting

3 VERIFY INSURANCE

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

4 SPECIFY PRESCRIPTION

- Be sure to check the box for the appropriate ICD-10-CM code for the diagnosis
- For commercial prescriptions, identify the patient's weight and date when it was taken, as well as the number of refills being requested
- This is a true prescription—a physician's wet signature and date are required

5 REQUEST INFORMATION

You can request more information about a variety of services and resources offered by Ultragenyx:

- Marketing and educational materials
- UltraCare patient services
- Consideration for future research projects

6 OBTAIN CONSENT

The patient's signature is required to allow protected health information (PHI) to be shared by third parties with Ultragenyx to facilitate access such as:

- Disclosure of information
- 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

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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 reverse side of this page.

Please see accompanying full Prescribing Information, including the **BOXED WARNING**, for a complete discussion of the risks associated with MEPSEVII.

ultragenyx pharmaceutical

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(vestronidase alfa-vjbk)
injection, for intravenous use
10 mg/5 mL (2 mg/mL)

UltraCare®

Patient Start Form

Toll-free line: 888-756-8657 **Fax:** 415-723-7474
Address: 5000 Marina Boulevard, Brisbane, CA 94005

1 PATIENT INFORMATION: Remember to choose your preferred contact method

First, Middle, Last Name _____ Gender ☐ Male ☐ Female
DOB (MM/DD/YYYY) _____ Last 4 digits of Social Security # _____
Street Address _____ City _____ State _____ ZIP Code _____
Home Phone (___) _____ Work (___) _____ Mobile (___) _____
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: Be sure to choose your preferred Site of Care (SOC)

☐ Home Infusion ☐ Office Administration ☐ Outpatient Hospital Setting Infusion Site Name _____
First and Last Name _____
Street Address _____ City _____ State _____ ZIP Code _____
Office Phone (___) _____ Fax _____ Email _____
Office Contact Name/Title _____ Office Contact Phone (___) _____
State License # _____ NPI # _____
☐ Site of Care (SOC) is Different Than the Prescriber SOC Name _____ SOC Address _____

"The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber."

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 MEPSEVII® (vestronidase alfa-vjbk) PRESCRIPTION INFORMATION: Select ICD-10-CM code and type of prescription

☐ ICD-10-CM E76.29 ☐ Other _____
4 mg/kg IV QOW. Dilute calculated dose with 0.9% sodium chloride 1:1 to be infused over approximately 4 hours.
Please see accompanying full Prescribing Information for additional information.

Commercial Prescription

MEPSEVII 10-mg/5-mL (2-mg/mL) single-dose vial Refills _____ **Patient's Weight** _____ kg **Date Taken** _____

Prescriber Signature _____ Date _____

(No Stamps) Dispense as Written
*The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Concurrent Medications _____ Special Instructions _____ Special Precautions (eg, allergies): _____

☐ Prescriber: Please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc as needed to administer the therapy.
☐ RN visit to provide education related to therapy, disease state, and nurse administration of MEPSEVII 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."

5 ADDITIONAL INFORMATION

☐ I would like to receive Ultragenyx marketing materials and other educational resources
☐ 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 market research projects. Please contact me to discuss the details of the market research projects

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

6 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 (_____) _____

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

I authorize each of my physicians, 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, 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 that 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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