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 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)

3 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

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 OBTAIN CONSENT

At Ultragenyx we value your privacy. The patient's signature is required to ensure patients agree to and understand how Ultragenyx collects and uses information.

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.

ICD-10-CM, *International Classification of Diseases, Tenth Revision Clinical Modification.*

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

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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 _____

Home Phone (___) _____ Work (___) _____ Mobile (___) _____ Best Time to Contact _____

Preferred Language _____ Email _____

Caregiver Name (First and Last) _____ Relationship to Patient _____ Caregiver phone (___) _____

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

☐ Patient does not have health insurance ☐ Patient demographic sheet provided

☐ Provide copies of all medical and prescription cards—front and back (primary and secondary, supplemental coverage)

3 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 _____

Office Phone (___) _____ Fax _____ Email _____

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

State License # _____ NPI # _____ Tax ID # _____

☐ 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.

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.

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PATIENT CONSENT TO SHARE AND USE PROTECTED HEALTH INFORMATION (PHI) [REQUIRED]

I understand that Ultragenyx Pharmaceutical Inc., and its agents, contractors, and other partners ("Ultragenyx") will need to obtain, review, use, and disclose my personal and medical information ("My Information") before I can receive assistance through the UltraCare Patient Services Program. For additional information about how Ultragenyx may collect and use personal information, including applicable U.S. state privacy rights and notices for different state residents, please visit www.ultragenyx.com/privacy-policy. Separate and apart from these policies, your data may also be subject to our Cookie Policy, if this form is accessed online.

Information to Be Disclosed: My Information related to my enrollment or participation in the Program may include but is not limited to:

- General information about me, including my name, birth date, last 4 digits of my social security number, and contact information
- Information about my medical records, including information about my medical history or treatment with this prescription medication or related medical conditions
- Information about my health benefits or health insurance coverage
- Financial information (as necessary), such as my income
- All information provided on this enrollment form and otherwise provided by me to UltraCare

Persons Authorized to Disclose and Use My Information: I authorize the following parties to disclose My Information to Ultragenyx:

- My healthcare providers, including any pharmacy that fills my prescription medication
- Any health plans, including my health insurance company, or programs that provide me with healthcare benefits

I also authorize Ultragenyx and its partners to redisclose My Information to the following parties:

- My healthcare providers, including the pharmacy that fills my prescription medication
- My health plans, including my health insurance company
- My authorized representative under federal or state law (if applicable)

Purposes for Which My Information May Be Used and Disclosed: My Information may be used and disclosed for the following purposes:

- Completing the enrollment process and verifying the information provided on my enrollment form, including confirming my identity and my use or potential use of the medication prescribed by my healthcare provider
- Establishing my eligibility for benefits from my health plan or other programs
- Providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including information on third-party resources that may be able to assist me
- Communicating with my healthcare providers and coordinating my prescription and medication through a pharmacy or healthcare provider's office
- Contacting me to evaluate the effectiveness of UltraCare
- Ultragenyx's internal business purposes, meeting legal requirements, and audit and compliance purposes
- Confirming my receipt of the prescribed Ultragenyx medication through UltraCare
- Deidentifying the information I provide, which means removing elements like my name and address so that I am no longer reasonably identifiable
- Identifying past UltraCare users in order to ensure continuity of service
- Contacting me about educational events, newsletters, resources, and potential opportunities to share my story and participate in market research, which I can unsubscribe from at any time without affecting my access to the UltraCare Patient Services Program

Other Important Points:

- I understand that I may choose not to sign this authorization. If I refuse, my eligibility for health plan benefits or ability to obtain treatment from my healthcare providers will not change, but I will not have access to the support offered by UltraCare. Program may not be combined with any third-party rebate, coupon, or offer
- I understand third-party vendors, such as specialty pharmacies, may receive financial remuneration in exchange for data, product support services, reimbursement services, etc
- Once I sign this Patient Authorization and My Information is transmitted to Ultragenyx and its partners, I understand that state and federal privacy laws may no longer protect, or prohibit the redisclosure of, My Information disclosed to Ultragenyx and its partners by my healthcare provider or others
- I understand that I am entitled to a copy of this signed authorization and that the authorization to share, disclose, and/or redisclose PHI 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 that I may cancel this authorization at any time by notifying my UltraCare representative or Ultragenyx directly at 1-888-756-8657 or by writing to the address listed at the top of this form. If I cancel, Ultragenyx will stop using this authorization to obtain, use, or disclose My Information after the cancellation date, but the cancellation will not affect uses or disclosures of My Information that have already been made pursuant to this authorization before the cancellation date
- More information on my privacy rights, including specific rights I may have, can be found in Ultragenyx's privacy policy (www.ultragenyx.com/privacy-policy/)

Patient Signature_____ **Date** _____

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

OPTIONAL TEXT MESSAGE CONSENT:

I consent to Ultragenyx Pharmaceutical Inc. and its agents, contractors, and assignees ("Ultragenyx") contacting me by text message using the mobile number provided on page 2 to provide me with Patient Services. By signing below, I attest that I have read and consent to the Terms of Service available here: https://www.ultracaresupport.com/TC.pdf.

Patient Signature_____ **Date** _____

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

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

(EXAMPLE: CAREGIVER, RELATIVE, AND/OR OTHER THIRD PARTY)

☐ 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 (_____) _____

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