ultragenyx pharmaceutical | UltraCare

Toll-free Line: 888-756-8657 | **Fax:** 415-723-7474 | **Web:** ultracaresupport.com
Email: UltraCare@ultragenyx.com | **Address:** 5000 Marina Boulevard, Brisbane, CA 94005

Patient Start Form

Please complete all 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 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 PRESCRIBER INFORMATION:

First Name _____ Last Name _____

Office/Clinic/Institution Name _____

State License # _____ NPI # _____ Tax ID# _____

Street Address _____

City _____ State _____ ZIP _____

Office Phone (_____) _____ Fax (_____) _____

Office Email _____

Office Contact Name/Title _____

Office Contact Phone (_____) _____ Office Contact Email _____

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

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 ☐ ENTERAL 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 ☐ Patient has had previous use of MCT
Discontinue use of MCT products before starting DOJOLVI. Initiate DOJOLVI at the last tolerated dose of MCT. Increase the total daily dose by approximately 5% DCI every 2 to 3 days until the target dose 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 dose to the nearest whole number
- Divide the total daily dose into at least 4 approximately equal individual doses

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

Total Daily Caloric Intake (DCI) _____

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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 per ☐ Dose or ☐ Day (choose one) every _____day(s) until reaching target _____mL daily dose *Use the Prescription Directions field below to describe alternate desired dosing protocols*	30-Day Supply	Dispense Quantity Sufficient to Complete Titration

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 _____

Please see full Prescribing Information at www.dojolvi.com for complete dosage and administration information.

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.

☐ This is an **opt-out** box. Ultragenyx ensures that patients enrolled in UltraCare are educated about and understand your prescription and disease management through Clinical Engagement Liaisons, who contact patients directly. By checking this box, you are **declining** this service for your patient.

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.

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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

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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 above 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:

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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 (_____) _____