FAYUVI™ rebisufligene etisparvovec-hopf suspension for IV infusion | UltraCare®

UPON ENROLLMENT, AN ULTRACARE GENE THERAPY GUIDE WILL:

- Be an educational resource for your enrolled patient or caregiver
- Contact the patient or caregiver to review insurance coverage and any available support programs

STEPS TO SUCCESSFUL ENROLLMENT IN ULTRACARE

Successful enrollment in the UltraCare Patient Support Services (Gene Therapy) Program requires completion of the following steps:

1&2 GET STARTED

- Fill out patient and referring physician information
- Identify the patient's weight and the date it was taken

3 SELECT QUALIFIED TREATMENT CENTER (QTC)

Choose the QTC for the administration of the medication:

- If known, indicate QTC contact information

4 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)

5 PRIMARY DIAGNOSIS ICD-10-CM CODE

Indicate the patient's primary diagnosis information.

6 OBTAIN CONSENT

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

If the patient and/or caregiver 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. Patient will not be enrolled into UltraCare without patient and/or caregiver consent.

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

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UltraCare®

Patient Enrollment Form

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

1 PATIENT INFORMATION:

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 (____) _____

Patient weight _____kg Date weight taken _____ (Final patient weight must be obtained in a medical office **within 11-15 calendar days of the scheduled infusion date**.)

2 REFERRING PHYSICIAN INFORMATION:

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 # _____

3 QUALIFIED TREATMENT CENTER (QTC) INFORMATION:

☐ QTC is the same as the site of care for referring physician listed above

☐ I would like assistance from UltraCare to help identify a QTC

☐ I would like to refer my patient to the QTC listed below

QTC site name _____ Address _____ City _____

State _____ ZIP _____ QTC site NPI _____

QTC contact _____ Phone _____ Fax _____ Email _____

4 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)

5 PRIMARY DIAGNOSIS ICD-10-CM CODE:

☐ E76.22 Sanfilippo Mucopolysaccharidosis Subtype: ____ ☐ Other: _____

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Patient Name _____ **DOB** _____ **Referring Physician Name** _____

6

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
- Genetic information, including genetic test orders and results
- 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)
- Laboratories and diagnostic testing providers performing tests in connection with my treatment
- Logistics and transportation providers, including those acting as independent controllers under their own privacy policies

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, including combining My Information with information obtained from other sources
- Confirming my receipt of the prescribed Ultragenyx medication through UltraCare
- Other activities as necessary to carry out the UltraCare Patient Support Services
- 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
- Coordinating specimen collection and transport services

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 services for which I may be eligible that are offered by UltraCare such as copay/coinsurance support, etc. 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 seven years from the date of execution, or seven years 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/)

Please review and check the boxes **to opt-in** to the following and sign where indicated below:

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 1 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)

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 Signature _____ **Date** _____

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

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