Laboratory Testing and Co-pay/ Financial Support Form for ROCTAVIAN™ (valoctocogene roxaparvovec-rvox)

Please sign, date, and fax completed form to 1.833.979.2207
To learn more about BioMarin RareConnections™ call **1.833.ROCTAVIAN** (1.833.762.8284), **hours M–F, 8 AM–8 PM (ET)**

ROCTAVIAN™ (valoctocogene roxaparvovec-rvox) Suspension for intravenous infusion

Complete these forms to explore the following financial support options for eligible* commercially insured patients:

- BioMarin RareConnections in partnership with Quest Diagnostics is providing a program for eligibility testing and post-infusion monitoring at Patient Service Centers or via Mobile Phlebotomy (the ROCTAVIAN Laboratory Support Program); State restrictions apply
- Co-pay assistance* for eligibility testing, post-infusion monitoring at a lab of your choice, and/or co-pay assistance for drug support

To enroll, complete pages 1 and 2 for co-pay assistance and all 3 pages for the ROCTAVIAN Laboratory Support Program. Your patient will also need to complete the Patient Consent Form (PCF) at ROCTAVIAN-PCF.com

All required fields are blue and bolded

PATIENT

First Name		**Last Name**	
Date of Birth (mm/dd/yyyy)	**Gender** ☐ Male ☐ Female ☐ Other		
Address			Floor/Suite/ Unit
City		**State**	**ZIP Code**
Primary Phone	Mobile Phone ☐ (same as primary)	**Email**	
Preferred Method of Contact ☐ Primary Phone ☐ Mobile Phone ☐ Email		**Preferred Language:** ☐ English ☐ Spanish ☐ Other language (please specify)	

INSURANCE

Provide copies of all medical and prescription cards — front and back			
☐ Patient has no insurance			
Primary Medical Insurance Name			**Insurance Phone**
Subscriber Name		**Relationship to Patient**	
Member ID	**Group**	**Plan Code**	
Prescription (PBM) Insurance Name			**Insurance Phone**
Subscriber Name			
Member ID	**RxBIN**	**RxPCN**	**RxGROUP**

PRESCRIBER

First Name		**Last Name**	
NPI Number			
Name of Institution/Practice			
Address			Floor/Suite/Unit
City		**State**	**ZIP Code**
Phone	**Fax**	**Email**	
Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email			

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Patient's Full Name	Date of Birth (mm/dd/yyyy)

DIAGNOSIS

ICD Code:

☐ D66.0 Hereditary factor VIII deficiency (please specify below)

- ☐ Classic hemophilia
- ☐ Deficiency factor VIII (with functional defect)
- ☐ Hemophilia NOS
- ☐ Hemophilia A

☐ Other diagnosis (Please specify) _____

PRESCRIBER DECLARATION

Prescriber Declaration: By signing below, I, as the prescribing physician, certify that the information provided on this form was completed by me or at my direction. I understand and agree that, as the Prescriber, I will comply with my 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 me, as the Prescriber.

I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed ROCTAVIAN™ (valoctocogene roxaparvovec-rvox) based on my professional judgment of medical necessity. I have informed my patient of the resources available in the BioMarin RareConnections™ program and have confirmed my patient's (or their respective caregiver's) consent to enroll in the program. I have obtained all required patient permissions and have complied with all federal and state laws with respect to disclosures and release of the provided information to BioMarin Pharmaceutical Inc., BioMarin RareConnections, and its affiliates, agents, and contractors (collectively, "BioMarin", as well as to or between other service providers such as laboratories and pharmacies, and for the purposes described herein by any means allowed under applicable law.

I understand that the information provided herein will be used for the purposes of BioMarin to investigate and verify patient's insurance and coverage benefits, to contact this patient to help obtain a signed patient consent form and/or to refer the patient to or contact the patient for purposes of enrollment in a patient education program, verify patient's insurance coverage benefits for ROCTAVIAN and any related services, to coordinate the dispensing and delivery of ROCTAVIAN (including transmitting the prescription to the appropriate pharmacies) utilizing the patient's benefit plan, assist in initiating or continuing therapy, provide prior authorization and appeals information, verify eligibility for a co-pay program, and identify additional financial resources, provide me and my patient with other education and support associated with ROCTAVIAN, and for BioMarin internal business purposes such as conducting quality control, data analysis, and gathering feedback to improve patient support and resources. By enrolling my commercially insured patient into the laboratory co-pay program, I acknowledge only those tests appropriate for determining eligibility and necessary follow-up for an FDA-approved use are eligible for co-pay support and that participation in the program is not contingent upon the recommendation, ordering, prescription, or purchase of any other product or service.

Prescriber's Signature. Please make a selection

Prescriber's Signature/Dispense as Written (no stamps or initials)	Date

*The BioMarin Co-Pay Assistance and ROCTAVIAN Laboratory Support Programs are valid only for those patients with commercial prescription insurance coverage for products who meet eligibility criteria. Offer not valid for prescriptions, administration, or related labs reimbursed, in whole or in part, by any federal, state, or government-funded insurance programs (for example, Medicare, Medicare Advantage, Medigap, Medicaid, VA, DoD, or TRICARE), for cash-paying patients, where product, administration, or related lab, are not covered by patient's commercial insurance, where patient's commercial insurance plan reimburses them for the entire cost of their prescription drug, administration, and/or related labs, or where prohibited by law or by the patient's health insurance provider. Patients who are residents of certain states (MA or RI) are not eligible for drug administration co-pay support. Patients who are residents of certain states (MI, MN, or RI) are not eligible for laboratory services co-pay support or the ROCTAVIAN Laboratory Support Program. Mobile Phlebotomy is not available to patients who are residents HI, AK, PR, and Guam due to dry ice requirements. If at any time a patient begins receiving prescription drug, administration, or related lab coverage under any such federal, state, or government-funded healthcare program, patient will no longer be able to use the BioMarin Co-Pay Assistance and ROCTAVIAN Laboratory Support Programs and patient must notify BioMarin RareConnections™ at 1.833.ROCTAVIAN (1.833.762.8284) to stop participation. Patients may not seek reimbursement for the value of the out-of-pocket expense amount covered by the BioMarin Co-Pay Assistance and ROCTAVIAN Laboratory Support Programs from any third-party payer, whether public or private. The BioMarin Co-Pay Assistance and ROCTAVIAN Laboratory Support Programs are valid ONLY for qualifying patients residing in the 50 U.S. states or in Puerto Rico with commercial insurance who have a valid prescription for an FDA-approved indication for the qualifying BioMarin therapy. The BioMarin Co-Pay Assistance and ROCTAVIAN Laboratory Support Programs are not health insurance. Offer may not be combined with any other rebate, coupon, or offer. Co-payment assistance under the BioMarin Co-Pay Assistance and ROCTAVIAN Laboratory Support Programs are not transferable. BioMarin Pharmaceutical Inc. reserves the right to rescind, revoke, or amend the BioMarin Co-Pay Assistance and ROCTAVIAN Laboratory Support Programs without notice. Patient/caregiver certifies responsibility for complying with applicable limitations, if any, of any commercial insurance and reporting receipt of program rewards, if necessary, to any commercial insurer. The BioMarin Co-Pay Assistance and ROCTAVIAN Laboratory Support Programs are subject to termination or modification at any time. Some restrictions apply.

Please sign, date, and fax the completed form to BioMarin RareConnections at: 1.833.979.2207

ROCTAVIAN Laboratory Support Program Testing Program Requisition Form

The ROCTAVIAN Laboratory Support Program provided by BioMarin RareConnections™ in partnership with Quest Diagnostics® offers eligibility testing and post-infusion monitoring to eligible commercially insured adults with severe hemophilia A. To determine if your patient is eligible for our program, please complete and sign the form below, then fax it to **BioMarin RareConnections at: 1.833.979.2207**

Service Type: ☐ Quest Patient Service Center ☐ Mobile Phlebotomy

Quest Enterprise Account #: **73929215**

CLIENT BILL ONLY No patient, Medicaid, Medicare, or third-party billing on this account. All below tests are covered by this program

PATIENT INFORMATION			PROVIDER INFORMATION			
Patient Name (Last)		Patient Name (First)	Ordering Physician Name			
Patient Date of Birth	Patient Sex ☐ Male ☐ Female	Patient ID (BioMarin Rare Connections to complete)	Physician NPI	Phone Number	Fax Number (for results)	State

TESTING ORDERS: Choose only one set of tests below per requisition form (either pre-infusion or post-infusion). A new requisition form is required for changes to testing protocols and frequency.

PRE-INFUSION (ELIGIBILITY)	TESTING FREQUENCY
☐ Pre-infusion tests inclusive of: • TC 30710 - Liver fibrosis and hepatic function panel with Fibrosis-4 (FIB-4) Index* *Hepatic Function Panel: Total Protein, Albumin, Globulin, Albumin/Globulin Ratio, Total Bilirubin, Direct Bilirubin, Indirect Bilirubin, Alkaline Phosphatase, Aspartate Aminotransferase (AST), Alanine Aminotransferase (ALT), Platelet Count, FIB 4 Index • TC 40083 - Factor VIII inhibitor	☐ Once (eligibility testing)

Provider to select testing protocol and frequency

POST-INFUSION TESTING – Protocol 1	TESTING FREQUENCY*
☐ Protocol 1 tests inclusive of: • TC 823 - ALT, Alanine aminotransferase • TC 822 - AST, Aspartate aminotransferase • TC 347 - Factor VIII (one-stage)	☐ Weekly ☐ Every 2 weeks ☐ Every 3 months ☐ Every 6 months (once) ☐ Other _____
POST-INFUSION TESTING – Protocol 2	
☐ Protocol 2 tests inclusive of: • TC 823 - ALT, Alanine • TC 822 - AST, Aspartate aminotransferase • TC 347 - Factor VIII (one-stage) • TC 374 - CPK, Creatine kinase	***Lab orders are for 6 months duration.**

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Prescriber Declaration: By signing below, I, as the prescribing physician, certify that the information provided on this form was completed by me or at my direction. I understand and agree that, as the Prescriber, I will comply with my 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 me, as the Prescriber. I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed ROCTAVIAN™ (valoctocogene roxaparvovec-rvox) based on my professional judgment of medical necessity. I have informed my patient of the resources available in the BioMarin RareConnections program and have confirmed my patient's (or their respective caregiver's) consent to enroll in the program. I have obtained all required patient permissions and have complied with all federal and state laws with respect to disclosures and release of the provided information to BioMarin Pharmaceutical Inc., BioMarin RareConnections, and its affiliates, agents, and contractors (collectively, "BioMarin"), as well as to or between other service providers such as laboratories and pharmacies, and for the purposes described herein by any means allowed under applicable law. I understand that the information provided herein will be used for the purposes of BioMarin to investigate and verify patient's insurance and coverage benefits, to contact this patient to help obtain a signed patient consent form and/or to refer the patient to or contact the patient for purposes of enrollment in a patient education program, verify patient's insurance coverage benefits for ROCTAVIAN and any related services, to coordinate the dispensing and delivery of ROCTAVIAN (including transmitting the prescription to the appropriate pharmacies) utilizing the patients benefit plan, assist in initiating or continuing therapy, provide prior authorization and appeals information, verify eligibility for a co-pay program, and identify additional financial resources, provide me and my patient with other education and support associated with ROCTAVIAN, and for BioMarin internal business purposes such as conducting quality control, data analysis, and gathering feedback to improve patient support and resources. By enrolling my commercially insured patient into the ROCTAVIAN Laboratory Support Program, I acknowledge only those tests appropriate for determining eligibility and necessary follow-up for an FDA-approved use are eligible for co-pay support and that participation in the program in not contingent upon the recommendation, ordering, prescription, or purchase of any other product or service.

Prescriber's Signature **Date**