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

Please sign, date, and fax completed form to 1.888.863.3361
To learn more about BioMarin RareConnections™ call **1.866.906.6100**, **hours M–F, 8 AM–8 PM (ET)**

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

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

- ARUP® Laboratories AAV5 DetectCDx™ testing via Mobile Phlebotomy; State restrictions apply
- Eligibility testing and post-infusion monitoring via Quest Diagnostics 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 pages 3 and/or 4 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**	
Office Contact Name		**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

– 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	Date

*Terms and Conditions apply. Valid only for patients with commercial prescription insurance coverage who have a valid prescription for an FDA-approved indication and who meet additional eligibility criteria. Not valid for prescriptions 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) or where prohibited by law or by the patient's health insurance provider. If at any time a patient begins receiving prescription drug coverage under any federal, state, or government-funded healthcare program, the patient will no longer be able to use the program and patient must notify BioMarin RareConnections at 1-866-906-6100 to stop participation. Patients residing in or receiving treatment in certain states may not be eligible for some or all of the program elements. Patients may not seek reimbursement for value received from the program from any third-party payers. Additional restrictions may apply. Offer subject to change or discontinuance without notice. This assistance offer is not health insurance. Click here or see **BioMarin-copay-terms.com** for full Terms and Conditions.

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ROCTAVIAN® Laboratory Support Program
AAV5 DetectCDx® Testing Program Form

The ROCTAVIAN Laboratory Support Program provided by BioMarin RareConnections™ in partnership with ARUP® Laboratories offers AAV5 DetectCDx® testing to adults with severe hemophilia A who are being prescribed ROCTAVIAN. CDx testing is a covered test, however eligibility for Mobile/ExamOne draws is only for 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: 1.888.863.3361**

PATIENT INFORMATION

Patient Name (Last)		Patient Name (First)	Patient ID
Patient Date of Birth	Patient Sex ☐ Male ☐ Female		

PROVIDER INFORMATION

Ordering Prescriber Name			
Mailing Address		State	Zip Code
Floor or Suite Number	Email		
Prescriber NPI	Phone Number	Fax Number (for results)	

AAV5 DetectCDx® via ARUP

AAV5 DetectCDx® (ELIGIBILITY)	LOCATION	TESTING FREQUENCY
☐ AAV5 DetectCDx® -AAV5 Total Antibody Assay for ROCTAVIAN (valoctocogene roxaparvovec-rvox) Eligibility in Hemophilia A (3000959)	☐ Mobile Phlebotomy ☐ ExamOne Location	☐ Once (eligibility testing)

PRESCRIBER DECLARATION

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Prescriber's Signature	**Date**

ROCTAVIAN® Laboratory Support Program Testing Program Requisition Form

☐ No patient or insurance changes

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: 1.888.863.3361**

Service Types: Quest patient service center (PSC) and Mobile Phlebotomy / ExamOne Locations

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 Prescriber Name			
Patient Date of Birth	Patient Sex ☐ Male ☐ Female	Patient ID	Prescriber 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)	LOCATION	TESTING FREQUENCY
☐ Pre-infusion tests inclusive of: • **TC 30710** - Liver fibrosis and hepatic function panel with Fibrosis-4 (FIB-4) Index* • **TC 40083** - Factor VIII inhibitor ☐ TC 16049 - Factor VIII (Chromogenic)	☐ Quest PSC ☐ Mobile Phlebotomy (W-Th-F)	☐ Once (eligibility testing)
☐ **TC 4914** - Prothrombin with INR and Partial Thromboplastin Times (PT/PTT/INR)	☐ Quest PSC ***(ONLY)***	☐ Once (eligibility testing)
☐ **TC 482** - Gamma-glutamyl transferase (GGT)	☐ Quest PSC ***(ONLY)***	☐ Once (eligibility testing)
Provider to select testing protocol and frequency		
POST-INFUSION TESTING – **Protocol 1**	LOCATION	TESTING FREQUENCY*
☐ Protocol 1 tests inclusive of: • TC 823 - ALT, Alanine aminotransferase • TC 822 - AST, Aspartate aminotransferase • ***Check one:*** ☐ TC 347 - Factor VIII (one-stage) -or- ☐ TC 16049 - Factor VIII (Chromogenic)	☐ Quest PSC ☐ Mobile Phlebotomy (W-Th-F)	☐ Weekly ☐ Every 2 weeks ☐ Every 3 months ☐ Every 6 months (once) ☐ Other ***Lab orders are for 6 months duration.**
POST-INFUSION TESTING – **Protocol 2**		
☐ Protocol 2 tests inclusive of: • TC 823 - ALT, Alanine • TC 822 - AST, Aspartate aminotransferase • ***Check one:*** ☐ TC 347 - Factor VIII (one-stage) -or- ☐ TC 16049 - Factor VIII (Chromogenic) • TC 374 - CPK, Creatine kinase	☐ Quest PSC ☐ Mobile Phlebotomy (W-Th-F)	

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Prescriber's Signature **Date**