Patient Enrollment Form for KUVAN® (sapropterin dihydrochloride) Tablets or Powder for Oral Solution

Fax completed form with prescriber's signature to **1.888.863.3361**
To learn more about BioMarin RareConnections™ call **1.866.906.6100, hours M–F, 8 AM–8 PM (ET)**

KUVAN® (sapropterin dihydrochloride) Tablets or Powder for Oral Solution

All required fields are purple and bolded

PATIENT

First Name	Middle Initial	**Last Name**	Suffix
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)	
Authorized Representative Name (if applicable)			Relationship to Patient
Phone		Email	

PRESCRIBER

First Name		**Last Name**	
Specialty		**NPI Number**	
State License Number	**Medicaid Number**	**Tax ID**	
Name of Institution/Practice			
Address			Floor/Suite/Unit
City		**State**	**ZIP Code**
Phone	**Fax**	**Email**	
Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email			
Primary Contact Name (if different from prescriber)			
Phone	Fax	Email	

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**

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

CLINICAL / DIAGNOSIS

If diagnosis is confirmed please fill out the information below:

ICD-10-CM

- ☐ Classical Phenylketonuria (PKU) E70.0
- ☐ Other Hyperphenylalaninemias E70.1 *(please specify)*
  - ☐ Phenylketonuria
  - ☐ Tetrahydrobiopterin Deficiency (BH4)
  - ☐ Hyperphenylalaninemia
  - ☐ Maternal Phenylketonuria
- ☐ Other Diagnosis *(please specify)* _____

Baseline blood Phe levels
(before trial)

Date Phe level measured (mm/dd/yyyy)

Patient allergies

☐ NKDA ☐ Yes (please list)

Concurrent medications

PRESCRIPTION

BioMarin will provide a 30-day supply of KUVAN® (sapropterin dihydrochloride) as a free trial for patients new to therapy

☐ Yes, provide patient with a free supply of KUVAN.

By checking this box, I, as the prescriber, with my signature below on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free product(s) provided by BioMarin. I agree and understand that any free product provided by BioMarin may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form.

Current weight _____ kg **Dose per kg body weight:** ☐ 10 mg/kg ☐ 20 mg/kg ☐ Other _____ mg/kg

Number of days' supply/prescription: ☐ 90 days ☐ 30 days Number of refills: One (1) year

☐ KUVAN, ***Powder 500 mg*** / Number of packets per day	NDC Number: 68135-482-10
☐ KUVAN, ***Powder 100 mg*** / Number of packets per day	NDC Number: 68135-301-11
☐ KUVAN, ***Tablet 100 mg*** / Number of 100 mg tablets per day	NDC Number: 68135-300-02

Patient Directions *(check all that apply)*: ☐ Please contact your physician before starting use of this medication.

☐ Take _____ 500 mg KUVAN (powder) and _____ 100 mg KUVAN (powder) once daily, as directed, with meal, for a total dose of _____ mg/day.

☐ Take _____ 100 mg KUVAN (tablet) once daily as directed, with meal, for a total dose of _____ mg/day.

☐ Other _____

Shipping Instructions
(check if applicable)

☐ Dispensing pharmacy to notify prescriber when initial shipment is scheduled.

Special Instructions

PRESCRIBER DECLARATION

Prescriber Declaration: 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 KUVAN based on my professional judgment of medical necessity. I authorize BioMarin Pharmaceutical Inc., its affiliates, agents, and contractors (collectively, "BioMarin") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the above-named patient utilizing their benefit plan. I also authorize the BioMarin RareConnections™ program to perform any steps necessary to secure reimbursement for KUVAN, including but not limited to insurance verification and case assessment. I understand that BioMarin or BioMarin RareConnections may need additional information, and I agree to provide it as needed for the purposes of securing reimbursement.

Prescriber's Signature. Please make a selection

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

PATIENT CONSENT FORM

To learn more about BioMarin RareConnections™
call 1.866.906.6100, hours M–F, 8 AM–8 PM (ET)

References to "you," "your," "I," "me," "my," etc. in this form are to the patient, even if an authorized representative is signing this form on the patient's behalf.

FOR BIOMARIN TO ASSIST YOU WITH ITS MEDICINES AND RELATED CARE, YOU WILL NEED TO PROVIDE CONSENT TO BOTH YOUR HEALTHCARE PROVIDER AND BIOMARIN:

- Your healthcare provider needs your written consent to release your protected health information (PHI) to BioMarin
- BioMarin needs your written consent to share your information with service providers such as laboratories and pharmacies to assist you with accessing services that support your treatment
- BioMarin needs your consent to contact you with marketing and other communications about BioMarin's products, services, programs, and other topics of interest for marketing, educational, or other purposes; to assist you in getting help through additional services that support your treatment plan; and to allow you to provide feedback to BioMarin through market research
- As described below, your consent is voluntary and is not required for treatment, medications, or other care. Your consent is required for BioMarin to provide the product support services described here
- BioMarin and its agents and representatives do not work under the direction of your healthcare provider or give medical advice; they are trained to direct patients to their healthcare provider for treatment-related advice

SECTION A: CONSENT TO SHARE HEALTH INFORMATION FOR PATIENT SUPPORT SERVICES

By signing this Patient Consent Form (PCF), I hereby authorize my healthcare providers, health insurance carriers, laboratory providers, and pharmacy providers (collectively, Healthcare Entities) to use and disclose my individual health and identifying information, including but not limited to health insurance information, medical diagnosis and condition (including but not limited to laboratory test results such as diagnostic results as well as test results related to diagnosis or supportive testing), prescription information, and name, date of birth, sex, address, and telephone number to BioMarin and its agents and representatives, including but not limited to third parties authorized by BioMarin, for them to use for the purposes listed below. I further authorize BioMarin to use my individual health and identifying information to administer the patient support program through BioMarin RareConnections™. Authorized purposes:

- to assist me with accessing services that support my treatment;
- to contact my healthcare provider and collect, enter, and maintain my health information in a database;
- to contact my insurers as needed to verify my insurance coverage, review reimbursement requirements, verify other financial assistance for which I might be eligible, assist with the processing of claims, or otherwise assist in obtaining coverage or financial assistance for my treatment, including but not limited to in relation to post-administration monitoring (n/a for Veteran's Administration (VA) patients);
- to determine eligibility for program offerings, including but not limited to financial assistance services (financial assistance n/a for VA patients);
- to determine eligibility for a BioMarin Co-Pay Assistance program, valid ONLY for qualifying patients residing in the 50 U.S. states or in Puerto Rico, where not prohibited by law, with commercial insurance, who are not a government beneficiary and/or participant in a federal or state-funded health insurance program, and who have a valid prescription for an FDA-approved indication for the qualifying BioMarin therapy; the BioMarin Co-Pay Assistance program pays for eligible out-of-pocket costs, where applicable, associated with a qualifying BioMarin therapy up to a maximum amount per calendar year;
- to contact me to follow up on any BioMarin RareConnections enrollment requirements, discuss and provide information and education on my treatment and any follow-up requirements, discuss the effectiveness of patient support services, and provide patient support services, education, and adherence reminders such as to take my BioMarin medication; and
- if I sign under Section 3, I further authorize BioMarin to use my individual and health and identifying information for the purposes described in Section B.

Once my health information has been disclosed to BioMarin, I understand that certain federal privacy laws may no longer protect the information. However, BioMarin intends to protect my health information by using and disclosing it only for purposes described in this PCF or as permitted by law or regulations. California residents, to learn more about the information BioMarin may collect about you, how we use that information, and your rights under the California Consumer Privacy Act (CCPA), please review our CCPA Privacy Policy, available at biomarin.com/data-privacy-center.

I understand that pharmacy providers, or others working on their behalf, may receive remuneration from BioMarin in exchange for patient therapy support services and data provided.

I understand that any product(s) provided under BioMarin's temporary Bridge Support program are for my/my child's personal use and will not be sold, traded, bartered, or transferred. Completing this form does not guarantee that I/my child will qualify for BioMarin's temporary Bridge Support program. In the event I become eligible for BioMarin's temporary Bridge Support program, I understand and agree as follows:

- BioMarin Bridge is not health insurance and is available for eligible patients only.
- Offer is available only to patients who have been diagnosed with an FDA-approved indication for a BioMarin therapy.
- No claim for reimbursement for product dispensed pursuant to this program may be submitted to my prescription insurance provider or any other third-party payer, including Medicare.
- To be eligible for Bridge, I/my child must be actively pursuing coverage through my insurance or awaiting a prior authorization/appeal decision.
- BioMarin Bridge does not require, nor will be made contingent on, purchase requirements of any kind.
- BioMarin reserves the right to amend, rescind, or discontinue this program at any time without notification.
- BioMarin Bridge can be dispensed only by the exclusive pharmacy and only after benefits investigation has been completed and a delay occurs in the prior authorization or appeals process or a new-to-market block by the payer has been confirmed.

- BioMarin Bridge is available only to patients in the U.S. and Puerto Rico.
- Prescription must be provided by a healthcare provider licensed in the U.S. or Puerto Rico.
- Additional eligibility criteria may apply. Contact BioMarin RareConnections for details.

This PCF expires in ten (10) years, or such shorter amount of time required by applicable state law, after the date I sign it as indicated by the date next to my signature, unless otherwise canceled earlier as set forth below. I understand I have a right to receive a copy of this PCF.

I understand that I may refuse to sign this PCF. I further understand that my treatment (including with a BioMarin product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this PCF, but if I do not sign it, or if I later cancel it, I will not be able to receive BioMarin's patient support services.

I understand that I may cancel this PCF at any time by mailing a letter to BioMarin at BioMarin RareConnections at 680 Century Point, Lake Mary, FL 32746 or emailing support@biomarin-rareconnections.com. Canceling this PCF will end my consent for my Healthcare Entities to further use and disclose my health information to BioMarin after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this PCF. Canceling this PCF will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

SECTION B: CONSENT FOR MARKETING/OTHER COMMUNICATIONS

By signing this Patient Consent Form (PCF), I hereby authorize my Healthcare Entities to use and disclose my individual health and identifying information to BioMarin for marketing purposes or to otherwise provide me with information about BioMarin products, services, research, clinical trials, and programs or other topics of interest, and to conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that BioMarin and companies working with BioMarin may use my individual health and identifying information to contact me by mail, email, fax, telephone call, or text message for these purposes. I understand and agree that any information that I provide may be used by BioMarin to help develop new products, services, and programs. I further understand that BioMarin will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission.

1 To authorize your consent, please complete all fields below.

Patient's First Name _____ Middle Initial _____ Patient's Last Name _____ Suffix _____ Date of Birth _____ Gender ☐ Male ☐ Female ☐ Other

Patient's/Authorized Representative's Name (if applicable) _____ Relationship to Patient _____

Patient's/Authorized Representative's Address _____ Floor/Suite/Unit _____ City _____ State _____ ZIP Code _____

Preferred Method of Contact (please specify) ☐ Primary Phone _____

☐ Mobile Phone (leave blank if mobile is primary phone) _____ ☐ Email _____

Preferred Language ☐ English ☐ Spanish ☐ Other Language (please specify) _____

2 Please read and sign below.

I have read and understand Section A in this PCF, the Consent to Share Health Information for Patient Support Services, and agree to the terms stated therein. A consent signature is required in order to receive BioMarin services.

Patient's/Authorized Representative's Signature _____ Date _____

Print Authorized Representative's Name (if applicable) _____ Relationship to Patient _____

3 Please read and sign below.

I have read and understand Section B in this PCF, the Consent for Marketing/Other Communications, and agree to the terms stated therein.

Patient's/Authorized Representative's Signature _____ Date _____

Print Authorized Representative's Name (if applicable) _____ Relationship to Patient _____

Print and fax your completed form (both pages) to 1.888.863.3361.

Note for healthcare providers: once your patient has completed this form, provide a copy to them and place the original in the patient's medical record.

BIOMARIN

BIOMARIN Rare Connections™