

UPON ENROLLMENT, AN ULTRACARE GUIDE WILL:

- Partner with and remain dedicated to the patient throughout the treatment journey
- Contact the patient or caregiver to review insurance coverage and support programs
- Assess the patient's eligibility for available financial assistance programs

GETTING STARTED: STEPS FOR SUCCESSFUL ENROLLMENT IN ULTRACARE

Below are the steps for ensuring complete and timely enrollment in UltraCare so the patient can benefit fully from the program's suite of support services.

1

SELECT PREFERRED PATIENT COMMUNICATION METHOD

- Ask the patient and/or caregiver about the preferred communication method and best time for an UltraCare Guide to establish contact

2

VERIFY THE PATIENT'S INSURANCE

- Provide a copy of the front and back of all of the patient's medical and prescription insurance cards
- Indicate if the patient does not have health insurance (medical and pharmacy)

3

PRESCRIBER INFORMATION

- Ensure accurate provision of information to reduce potential for follow up

Patient Start Form

Please complete all pages to ensure successful enrollment

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

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

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 _____

GETTING STARTED: STEPS FOR SUCCESSFUL ENROLLMENT IN ULTRACARE (cont'd)

Below are the steps for ensuring complete and timely enrollment in UltraCare so the patient can benefit fully from the program's suite of support services.

4

SPECIFY PRESCRIPTION FOR DOJOLVI® (triheptanoin) oral liquid

• Dose calculation

- Caloric value of DOJOLVI = 8.3 kcal/mL
- Round the total daily dosage to the nearest whole number
- Divide the total daily dosage into at least 4 approximately equal individual doses
- A table is included, with information and formulas for dose calculation, allowing for the designation of a titration or maintenance dose
- Ensure the prescriber's wet signature and date are included, which are necessary to process the prescription

CLINICAL ENGAGEMENT LIAISON

- Unless opted out, a clinical engagement liaison will contact the patient with education on the prescription and disease state



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

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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

- | | |
|---|---|
| <input type="checkbox"/> E71.30 (disorder of fatty-acid metabolism, unspecified) | <input type="checkbox"/> E71.31 (disorders of fatty-acid oxidation) |
| <input type="checkbox"/> E71.310 (long-chain/very long-chain acyl-CoA dehydrogenase deficiency) | <input type="checkbox"/> E71.314 (muscle carnitine palmitoyltransferase deficiency) |
| <input type="checkbox"/> E71.318 (other disorders of fatty-acid oxidation) | <input type="checkbox"/> E71.39 (other disorders of fatty-acid metabolism) |
| <input type="checkbox"/> Other _____ | |

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

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

Total Daily Caloric Intake (DCI) _____					30-Day Supply		Dispense Quantity Sufficient to Complete Titration	
<input type="checkbox"/> 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 _____ day (or (choose one) _____ day) until reaching target _____ mL daily dose <small>Use the Prescription Directions field below to describe alternate dosing protocols</small>				
Prescription Directions								

<input type="checkbox"/> 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.

GETTING STARTED: STEPS FOR SUCCESSFUL ENROLLMENT IN ULTRACARE (cont'd)

Below are the steps for ensuring complete and timely enrollment in UltraCare so the patient can benefit fully from the program's suite of support services.

5 OBTAIN PATIENT CONSENT*

- Obtain the patient's signature, unless opted out, to allow third parties to share protected health information with Ultragenyx and facilitate:
 - Benefits investigation
 - Prior authorization
 - Specialty pharmacy provider prescription transfer
- Additional services provided by UltraCare, including insurance coverage, financial assistance, and patient support programs
- Opt-in for text message communication
- Other practices identified in the consent form

6 DETERMINE DISCLOSURE PERMISSIONS

- Indicate if the patient would like to allow for his or her information to be shared with other individuals



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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

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:

Name _____ Relationship to Patient ☐ Primary ☐ Secondary ☐ Tertiary
Street Address _____
City _____ State _____ ZIP _____
Phone (_____) _____

*If the patient 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 enrollment form.