PaTHforward TRIAL

Yorvipath® palopegteriparatide Injection 300 mcg/mL

PaTH Forward Transition Enrollment Form

Fax: 1-888-436-0193 | **Phone: 1-844-44ASCENDIS** (1-844-442-7236) | **Email:** info@ascendissupport.com

❑ **Transition from PaTH Forward clinical trial** Site name: _____

Service(s) Requested

Check all that apply:

❑ Reimbursement support ❑ Injection training ❑ A·S·A·P Bridge Support ❑ YORVIPATH Co-Pay Program enrollment

❑ Ascendis Patient Assistance Program ❑ *Extra Help* program assistance*

Patient Information

First name: _____ M.I.: _____ Last name: _____

Date of birth: _ _ / _ _ / _ _ _ _ Gender: ❑ M ❑ F ❑ Other

Street address: _____ City: _____ State: ____ ZIP: _____

Mobile phone #: _____ Home phone #: _____ Email: _____

Caregiver first name: _____ Last name: _____ Phone #: _____ Relationship to patient: _____

Insurance Information

Please attach copies of both sides of patient's insurance card(s). ❑ **Check if patient does not have insurance**

Primary Medical Insurance: _____ Insurance phone #: _____

Policy # / Member ID #: _____ Group #: _____

Policy holder's name: _____ Relationship to patient: _____

Primary Pharmacy Insurance: _____ Pharmacy plan phone #: _____

Policy ID #: _____ Group #: _____ Rx BIN #: _____ Rx PCN #: _____

Was a prior authorization already submitted? ❑ Yes ❑ No Date of submission: _ _ / _ _ / _ _ _ _

Diagnosis

Cause of hypoparathyroidism:

❑ E89.2 Postprocedural hypoparathyroidism

Date of surgery: _ _ / _ _ / _ _ _ _

Date of diagnosis: _ _ / _ _ / _ _ _ _

❑ E20 Hypoparathyroidism

❑ E20.0 Idiopathic hypoparathyroidism

❑ E20.8 Other hypoparathyroidism

❑ E20.9 Hypoparathyroidism, unspecified

❑ D82.1 Di George's syndrome

Hypoparathyroidism Treatment History

Please confirm patient's serum calcium level:

Serum calcium level: _____

Date: _ _ / _ _ / _ _ _ _

❑ **My patient has hypoparathyroidism and it's not well controlled with calcium supplements and active vitamin D alone**

Calcium supplement dose (mg elemental calcium/day): _____ Date: _ _ / _ _ / _ _ _ _

Calcitriol daily dose (mcg/day): _____ Date: _ _ / _ _ / _ _ _ _

24-hour urine calcium (mg/24 h): _____ Date: _ _ / _ _ / _ _ _ _

Serum 25(OH) vitamin D (ng/mL): _____ Date: _ _ / _ _ / _ _ _ _

Prescriber Information

Prescriber name: _____

Practice: _____

DEA #: _____

Prescriber Tax ID #: _____

Prescriber NPI #: _____

Address: _____

City: _____ State: _____

ZIP: _____

Office contact: _____

Office phone #: _____

Office fax: _____

Office email: _____

YORVIPATH Prescription and Physician Signature

The recommended starting dose is 18 mcg once daily.

YORVIPATH Prescription: _____ mcg once daily

Quantity: 28 days

Refills: _____

Dose is only to be adjusted per physician's instruction and may be titrated to an optimal dose in increments or decrements of 3 mcg/day with the daily dose ranging from 6 to 30 mcg/day.

Injections are administered subcutaneously once daily to the abdomen or front of the thigh while rotating the injection site daily.

Concurrent medications: _____

Special precautions (eg, allergies): _____

PRESCRIBER AUTHORIZATION Prescriber certifies that he/she has obtained consent to release the patient's health information to A·S·A·P in conjunction with the services working solely on behalf of the patient for the purposes of seeking reimbursement through A·S·A·P; verifying insurance coverage; arranging for services; and evaluating the patient's eligibility for alternate sources of funding, patient support services, and materials and product fulfillment via Specialty Pharmacies. 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. I authorize ancillary supplies, such as sharps containers, alcohol swabs, etc, to administer the therapy. For purposes of transmitting these prescriptions, I authorize Ascendis, its affiliates, business partners, and agents to forward as my agent for these limited purposes these prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

❑ Dispense as written

Prescriber Signature: _____

Date: _ _ / _ _ / _ _ _ _

❑ Substitution allowed

Prescriber Signature: _____

Date: _ _ / _ _ / _ _ _ _

Injection Training

INJECTION TRAINING AUTHORIZATION A·S·A·P will provide my patient with training from a company-funded program on the proper self-administration of YORVIPATH. I will receive information on my patient's injection training via the fax number I provided above. This order is valid for 1 year.

❑ **I do not wish to have training coordinated for my patient by A·S·A·P.** By checking this box and opting out of injection training, I acknowledge that I will assume responsibility and arrangements for YORVIPATH injection training for this patient.

*Medicare Part D low-income subsidy program.

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A·S·A·P ASCENDIS SIGNATURE ACCESS PROGRAM®