Yorvipath®
palopegteriparatide

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

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

❑ **New to YORVIPATH®**
❑ **Continuing on YORVIPATH**
❑ **Transitioning from oral calcium and active vitamin D**
❑ **Switching from PTH therapy:** _____

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
❑ Other: _____

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 the appropriate 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.

ascendis pharma