



**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 **1.877.MY.KUVAN** (1.877.695.8826),
hours M–F, 8 AM–8 PM (ET)



All required fields are purple and bolded

PATIENT	First Name		Middle Initial	Last Name		Suffix
	Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other			
	Address					Floor/Suite/ Unit
	City				State	ZIP Code
	Primary Phone		Mobile Phone <input type="checkbox"/> (same as primary)		Email	
	Preferred Method of Contact <input type="checkbox"/> Primary Phone <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Email				Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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 <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email					
Primary Contact Name (if different from prescriber)						
Phone			Fax		Email	
INSURANCE	Provide copies of all medical and prescription cards — front and back					
	<input type="checkbox"/> 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)
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CLINICAL / DIAGNOSIS	If diagnosis is confirmed please fill out the information below:		
	ICD-10-CM	Baseline blood Phe levels (before trial)	
	<input type="checkbox"/> Classical Phenylketonuria (PKU) E70.0 <input type="checkbox"/> Other Hyperphenylalaninemias E70.1 (please specify) <input type="checkbox"/> Phenylketonuria <input type="checkbox"/> Tetrahydrobiopterin Deficiency (BH4) <input type="checkbox"/> Hyperphenylalaninemia <input type="checkbox"/> Maternal Phenylketonuria <input type="checkbox"/> Other Diagnosis (please specify) _____	Date Phe level measured (mm/dd/yyyy)	
	Patient allergies <input type="checkbox"/> NKDA <input type="checkbox"/> 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		
	<input type="checkbox"/> 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: <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> 20 mg/kg <input type="checkbox"/> Other _____ mg/kg Number of days' supply/prescription: <input type="checkbox"/> 90 days <input type="checkbox"/> 30 days Number of refills: One (1) year		
	<input type="checkbox"/> KUVAN, Powder 500 mg / Number of packets per day	NDC Number: 68135-482-10	
	<input type="checkbox"/> KUVAN, Powder 100 mg / Number of packets per day	NDC Number: 68135-301-11	
<input type="checkbox"/> KUVAN, Tablet 100 mg / Number of 100 mg tablets per day	NDC Number: 68135-300-02		
Patient Directions (check all that apply): <input type="checkbox"/> Please contact your physician before starting use of this medication. <input type="checkbox"/> Take _____ 500 mg KUVAN (powder) and _____ 100 mg KUVAN (powder) once daily, as directed, with meal, for a total dose of _____ mg/day. <input type="checkbox"/> Take _____ 100 mg KUVAN (tablet) once daily as directed, with meal, for a total dose of _____ mg/day. <input type="checkbox"/> Other _____			
Special Instructions		Shipping Instructions (check if applicable) <input type="checkbox"/> Dispensing pharmacy to notify prescriber when initial shipment is scheduled.	

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)

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

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. I further authorize BioMarin to use my individual health and identifying information to administer the patient support program through BioMarin RareConnections™ and BioMarin’s Clinical Coordinator Program and for the following additional purposes:

- 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;
- to determine eligibility for program offerings, including but not limited to financial assistance services; and
- to contact me to follow up on any BioMarin RareConnections enrollment requirements, receive education, discuss and provide information and education on my treatment and any follow-up requirements, discuss the effectiveness of support services, and provide support services, education, and adherence reminders such as to take my BioMarin medication. BioMarin Clinical Coordinators do not work under the direction of your healthcare provider or give medical advice. BioMarin Clinical Coordinators are trained to direct patients to their healthcare provider for treatment-related advice

Once my health information has been disclosed to BioMarin, I understand that federal privacy laws no longer protect the information. However, BioMarin agrees to protect my health information by using and disclosing it only for purposes authorized in this PCF or as required 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 the health information and/or for any therapy support services provided.

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 therapy 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 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.

SECTION C: BIOMARIN CO-PAY ASSISTANCE PROGRAM ELIGIBILITY

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. The program is 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 have a valid prescription for an FDA-approved indication for the qualifying BioMarin therapy. By participating in the program, patients acknowledge that they understand and agree to comply with the complete program terms and conditions available at BioMarin-RareConnections.com or on request by contacting BioMarin RareConnections at 1.866.906.6100.

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	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> 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) <input type="checkbox"/> Primary Phone _____								
<input type="checkbox"/> Mobile Phone (leave blank if mobile is primary phone) _____ <input type="checkbox"/> Email _____								
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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 Sections B and C in this PCF, the Consent for Marketing/Other Communications and the Co-Pay Assistance Program Eligibility, 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.