Patient Enrollment Form for NAGLAZYME® (galsulfase)

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)**

Naglazyme® (GALSULFASE)

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)

INFUSION SITE

Infusion Site Name			
Address			Floor/Suite/Unit
City		State	ZIP Code
Infusion Site NPI	Infusion Site Tax ID	Infusion Site Contact (if available)	
Phone	Fax	Email	

CLINICAL/DIAGNOSIS

If diagnosis is confirmed please fill out the information below:

☐ ICD-10 Code (Other, Mucopolysaccharidosis, E76.29)	☐ Other diagnosis *(please specify)*	Date of diagnosis (mm/dd/yyyy)

Lab performing diagnosis

Method of diagnosis ☐ Biochemical/Enzyme testing ☐ Molecular testing

Patient allergies

☐ NKDA ☐ Yes (please list)

Concurrent medications

PRESCRIPTION

For Use by In-Network Specialty Pharmacy Only—Not for Home Infusion

Product name: NAGLAZYME® (galsulfase), concentrate for infusion		NDC Number: 68135-020-01
Current weight (kg)	**Date weight measured (mm/dd/yyyy)**	**Dose (mg per week)**
Dispense: Number of days' supply/Rx: ☐ 30 days ☐ 90 days Refills: One (1) year		**Direction for use:** Infuse _____ mg every week in _____ mL normal saline over _____ hours

Preferred Procurement Method

☐ Buy and Bill ☐ Specialty Pharmacy

PRESCRIBER DECLARATION

Prescriber Declaration: 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 NAGLAZYME® (galsulfase) based on my professional judgment of medical necessity. I authorize BioMarin or its affiliated companies or subcontractors to forward this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the above-mentioned patient. I also authorize BioMarin to perform any steps necessary to obtain reimbursement for NAGLAZYME, including but not limited to insurance verification and case management. I understand that BioMarin may need additional information, and I agree to provide it as needed for purposes of 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

No stamps or initials: If you are a New York prescriber, please use an original New York State prescription form.

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 ☐ 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 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.

BIOMARIN

BIOMARIN Rare Connections™