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**
Phone: **1.877.MY.KUVAN** (1.877.695.8826); Hours: M–F, 6AM–5PM (PT)
Email: **support@biomarin-rareconnections.com**

KUVAN® (sapropterin dihydrochloride) Tablets or Powder for Oral Solution

All required fields are purple and are noted with an asterisk*

PATIENT

Patient Last Name*		**Patient First Name***	
Date of Birth*	**Gender*** ☐ Male ☐ Female ☐ Other	Parent/Guardian Name (if applicable)	
Street Address*		Suite/Floor/Apt	
City*		**State***	**ZIP Code***

Preferred Method of Contact (please specify)*

☐ Cell Phone ☐ Home Phone ☐ Work Phone

☐ Email

Language Preferred: ☐ English ☐ Other Language (please specify)

Alternate Contact Name	Relationship to Patient
Phone	Email

INSURANCE

Please attach copies of the insurance and prescription benefit cards, front and back, or complete the following* ☐ Patient has no insurance.

Primary Insurance Name*		Secondary Insurance Name	
Insurance Phone Number*		Insurance Phone Number	
Subscriber*		Subscriber	
Relationship to Patient*		Relationship to Patient	
Member ID*	Group ID	Member ID	Group ID
Employer*		Employer	

DIAGNOSIS/CLINICAL

Diagnosis ICD-10-CM*

Baseline Blood Phe Levels *(before trial)*

☐ Classical Phenylketonuria (PKU) E70.0

☐ Other Hyperphenylalaninemias E70.1 *(please specify)*

- ☐ Phenylketonuria
- ☐ Tetrahydrobiopterin Deficiency (BH4)
- ☐ Hyperphenylalaninemia
- ☐ Maternal Phenylketonuria

☐ Other Diagnosis *(please specify)* _____

Date

Prolonged elevated blood phenylalanine (Phe) in adults can result in neurocognitive and neuropsychiatric impairment. I am prescribing KUVAN for this patient, and find it medically necessary to reduce blood Phe levels for this patient.

I am prescribing KUVAN for this patient, and find it medically necessary for the following reasons (check all that apply):

☐ I want to reduce blood Phe levels in this patient. ☐ Other _____

Additional Comments

Patient Allergies? ☐ Unknown ☐ Known If known allergies, please list _____

Please list the names of other medications the patient is currently taking

☐ None

Patient Full Name*	Date of Birth*

PRESCRIBER

Prescriber Last Name*	Prescriber First Name*	Prescriber Specialty: ☐ Genetics ☐ Internal Medicine ☐ Other (please specify)	
Office/Site/Clinic*		Office Contact	Office Contact Phone Number
Phone Number*	Fax Number*	Email	
Street Address*			
City*		State*	ZIP Code*
State License Number		Medicaid Number	
Tax ID		NPI Number*	

PRESCRIPTION

BioMarin will provide a 30-day supply of KUVAN® (sapropterin dihydrochloride) as a free trial for patients new to therapy

☐ 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: ☐ 10 mg/kg ☐ 20 mg/kg ☐ Other _____ mg/kg

Number of days' supply/prescription: ☐ 90 days ☐ 30 days Number of refills: One (1) year

☐ KUVAN, ***Powder 500 mg*** / Number of packets per day	NDC Number: 68135-482-10
☐ KUVAN, ***Powder 100 mg*** / Number of packets per day	NDC Number: 68135-301-11
☐ KUVAN, ***Tablet 100 mg*** / Number of 100 mg tablets per day	NDC Number: 68135-300-02

Patient Directions *(check all that apply)*:

☐ Please contact your physician before starting use of this medication.

☐ Take _____ 500 mg KUVAN (powder) and _____ 100 mg KUVAN (powder) once daily, as directed, with meal, for a total dose of _____ mg/day.

☐ Take _____ 100 mg KUVAN (tablet) once daily as directed, with meal, for a total dose of _____ mg/day.

☐ Other _____

Shipping Instructions *(check if applicable)*

☐ Dispensing pharmacy to notify prescriber when initial shipment is scheduled.

Bridge Prescription†

☐ Check the box for Sonexus Health Pharmacy to dispense a bridge fill for KUVAN prescriptions if needed.

†Bridge prescription is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge prescription is intended to support continuation of prescribed therapy if there is a delay in insurance coverage determination. By checking the box above for bridge prescription, 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. BioMarin reserves the right to modify or terminate the program without notice at any time.

SPECIAL INSTRUCTIONS

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 Signature. Please make a selection*

Prescriber Signature/Dispense As Written (no stamps or initials) Date	Prescriber Signature/Substitution Permitted (no stamps or initials) Date