For Patients

(Sections 1–4 to be read and completed by Patient or Patient's Authorized Representative)

The purpose of this form is to permit HoFH patients who have been prescribed EVKEEZA® (evinacumab for injection) to receive information and support ("Patient Support") from UltraCare and its affiliates, representatives, agents, and contractors. UltraCare provides Patient Support to eligible patients who have been prescribed EVKEEZA. This includes: (1) providing reimbursement and financial support to eligible patients (such as investigating your insurance coverage and reviewing eligibility for financial assistance); (2) working with you and your provider to fill your prescription; (3) providing you with disease- and medication-related educational resources and communications; and (4) coordinating EVKEEZA infusions.

The UltraCare Program ("Program") is sponsored by Ultragenyx Pharmaceutical, Inc. ("Ultragenyx"), and administered by Innomar on behalf of Ultragenyx.

Please read this form carefully and ask any questions that you may have before signing.

1. PATIENT INFORMATION (Be sure to choose your preferred contact method)

First, middle, last name _____

Gender ☐ Female ☐ Male ☐ Other DOB (DD/MM/YYYY) _____

Health card number _____

Home phone _____ Work phone _____

Mobile phone _____ Best time to contact _____

Preferred method of contact: ☐ Home ☐ Work ☐ Mobile ☐ Email

I consent to receiving voicemails: ☐ Yes ☐ No

Street address _____

City _____

Province _____ Postal code _____

Email (optional) _____

Caregiver name (first and last) _____

Relationship to patient _____ Caregiver phone _____

Preferred language: ☐ English ☐ French ☐ Other _____

2. PATIENT CONSENT TO COLLECT, USE, AND SHARE PERSONAL INFORMATION ("PI") AND SIGNATURE

I understand that the UltraCare Program ("Program") is sponsored by Ultragenyx Pharmaceutical, Inc. ("Ultragenyx"), and administered by Innomar on behalf of Ultragenyx. I understand that other service providers may be appointed by Ultragenyx to administer the Program from time to time.

For additional information about how Ultragenyx may collect and use personal information, including your privacy rights, please visit www.ultragenyx.com/privacy-policy. Separate and apart from these policies, your data may also be subject to our Cookie Policy if this form is accessed online.

INFORMATION TO BE DISCLOSED:

I authorize each of my physicians and pharmacists (including any specialty pharmacies and other healthcare providers) and each of my health insurers to disclose my PI (e.g., to Ultragenyx, its agents, contractors, and assignees), including but not limited to:

- General information about me, including my name, birth date, address, and contact information
- Information related to lab values or treatment with this prescription medication or related medical conditions
- Financial information (as necessary) and insurance coverage information
- Information about my health benefits
- All information provided on this enrolment form and otherwise provided by me to UltraCare

DISCLOSURE AND USE OF MY INFORMATION:

I authorize Ultragenyx and its agents, contractors, and assignees to collect, use, and disclose my PI to manage and administer the Program, including to:

- Enrol me in and contact me about UltraCare Patient Services
- Provide case management through telephone or electronic communications to assist with adherence to my medication regimen
- Work with third parties to provide community resources and referrals (e.g., metabolic dietitian, genetic counselling, patient support organizations, pharmacy coordination for refills or renewals)

I also authorize Ultragenyx and its partners to redisclose my PI to the following parties:

- My physicians and pharmacists (including any specialty pharmacies and other healthcare providers)
- My private or public health insurance providers (e.g., provincial or federal plans)

I also authorize the collection, use, and disclosure of my PI in order to meet legal obligations to report adverse drug events to health authorities and to monitor product complaints.

I understand that Ultragenyx may contact me or my healthcare providers for additional information to fulfill its reporting obligations.

I also understand that my PI may be combined with the information of others who participate in the Program in order to generate aggregated data to improve the Program, to design and implement other patient programs, for business purposes, and to conduct research, including to identify trends such as product utilization, adherence, or outcomes.

My Information May Also Be Used and Disclosed for the Following Purposes:

- Completing the enrolment process and verifying the information provided on my enrolment form, including confirming my identity and my use, or potential use, of the medication prescribed by my healthcare provider
- Providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including information on third-party resources that may be able to assist me
- Contacting me to evaluate the effectiveness of the Program
- Fulfilling Ultragenyx's internal business purposes, meeting legal requirements, and meeting audit and compliance criteria
- Confirming my receipt of the prescribed Ultragenyx medication through the Program
- Removing identifiers from the information I provide, which means removing elements like my name and address so that I am no longer reasonably identifiable
- Identifying past UltraCare users in order to ensure continuity of Program service
- Contacting me about educational events, newsletters, resources, and potential opportunities to share my story and participate in market research, which I can unsubscribe from at any time without affecting my access to the UltraCare Patient Services Program (see section 3 to consent).

Other Important Points:

- I understand that Ultragenyx and its agents, contractors, and assignees may store or process my PI outside of Canada (including in the United States), where local laws may require the disclosure of PI to government authorities under circumstances different from those in Canada. I also understand that, in such cases, my privacy rights may no longer protect or prohibit the redisclosure of my PI.
- I understand that I may refuse to sign this consent, in which case, I will not be enrolled in the Program and will not have access to the support offered by UltraCare. I also understand that my treatment and eligibility for health benefits, including my access to therapy, will not be otherwise conditioned on my signing this consent.
- More information on my privacy rights, including specific rights I may have, can be found in Ultragenyx's privacy policy (www.ultragenyx.com/privacy-policy/).
- I understand that I am entitled to a copy of this signed consent and that the consent to share, disclose, and/or redisclose PHI expires one year from the date of execution, or one year after the date of my last prescription, whichever is later, unless a shorter period is required.
- I understand third-party vendors, such as specialty pharmacies, may receive financial remuneration in exchange for data, product support services, reimbursement services, etc
- I understand that I may revoke this consent at any time by notifying my UltraCare representative or by writing to the address listed at the bottom of this form. If I revoke, Ultragenyx will not collect additional PI after the revocation date, but the revocation will not affect uses or disclosures of my PI that have already been made before the revocation date.
- I understand that I may contact the Program at any time to update, access, or modify my PI, express a privacy-related concern, or inquire about the privacy practices of the Program. More information on my privacy rights, including specific rights I may have, can be found in Ultragenyx's privacy policy (www.ultragenyx.com/privacy-policy/).

Print Patient or Authorized Patient Representative Name	X Signature of Patient or Authorized Patient Representative	Relationship to Patient	Date

Patient Name _____ DOB (MM/DD/YYYY) _____

2. PATIENT CONSENT TO COLLECT, USE, AND SHARE PERSONAL INFORMATION ("PI") AND SIGNATURE (*CONT.*)

IMPORTANT: If healthcare provider is unable to obtain written consent from patient, please document when patient verbal consent was obtained. This will allow the Program to continue with processing this enrolment. Written consent will be obtained by the Program. Verbal consent should be obtained by a healthcare provider.

☐ Patient consented verbally Date (DD/MM/YYYY) _____

Patient consent obtained by: Name (Last, First)

_____

Title: ☐ MD ☐ RN ☐ Other (specify)_____

Signature

_____

By providing my email address, I agree to receive, electronically, communications from Innomar acting on behalf of Ultragenyx Pharmaceutical, Inc., containing information and updates relating to my enrolment in the UltraCare Program. I understand that I may withdraw my consent to such communications at any time by providing notice to Innomar Strategies, Inc., c/o UltraCare Program, 2600 Alfred Nobel Blvd., Ville Saint-Laurent, QC H4S 0A9, or via email at ultracare@innomar-strategies.com.

OPTIONAL TEXT MESSAGE CONSENT:
I consent to Ultragenyx Pharmaceutical, Inc., and its agents, contractors, and assignees ("Ultragenyx") contacting me by text message using the mobile number provided above to provide me with Patient Services. By signing below, I attest that I have read and consent to the Terms of Service available here: https://www.ultracaresupport.com/TC.pdf.

	X		
Print Patient or Authorized Patient Representative Name	**Signature of Patient or Authorized Patient Representative**	**Relationship to Patient**	**Date**

3. AUTHORIZATION FOR ULTRACARE® AND COMMUNICATIONS

By signing below, I confirm I would like to enrol in the UltraCare Program and authorize UltraCare to provide me with Patient Support. I understand that UltraCare is an optional program. I agree that UltraCare may use My Information and share it with My Providers or My Plan in connection with providing the Patient Support, administering the UltraCare Program, or as otherwise required by UltraCare to meet its legal obligations. For example, UltraCare may communicate with me (such as by mail, phone, email, and/or text message) or my caregiver, use My Information to tailor the UltraCare-related communications to my needs, and share information with My Providers about dispensing my EVKEEZA medicine to me. I understand that UltraCare may de-identify My Information, combine it with information about other patients, and use the resulting information for UltraCare reporting purposes.

PLEASE SEND ME:

☐ Information on Ultragenyx educational events, newsletters, and resources
☐ Invitation to share my story and to participate in relevant Ultragenyx market research projects

	X		
Print Patient or Authorized Patient Representative Name	**Signature of Patient or Authorized Patient Representative**	**Relationship to Patient**	**Date**

4. OPT IN TO RECEIVE MARKETING COMMUNICATIONS (NOT REQUIRED FOR ULTRACARE® ENROLMENT)

By checking this box, I authorize UltraCare, and companies working with UltraCare, to contact me by mail, email, fax, and/or telephone regarding marketing and promotional communications, customer surveys, or for market research surveys. **I understand that I am not required to provide this consent to receive marketing communications in order to receive EVKEEZA or UltraCare services.**

	X		
Print Patient or Authorized Patient Representative Name	**Signature of Patient or Authorized Patient Representative**	**Relationship to Patient**	**Date**

For Healthcare Providers

(Sections 5-9 to be read and completed by Healthcare Provider)

5. PRESCRIBER INFORMATION

First name _____
Last name _____
Office email _____
Office contact name/title _____
Office contact phone _____
Licence # _____

Street address _____
City _____
Province _____ Postal code _____
Office phone _____
Fax _____
Prescriber email _____

6. CONFIRMED DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH) BY:

☐ Clinically diagnosed

☐ Genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the *LDLR*, *APOB*, *PCSK9*, or *LDLRAP1* genes

☐ Confirmed diagnosis of OTHER

_____

Patient Name _____ DOB (MM/DD/YYYY) _____

7. PATIENT HISTORY

Patient Status and History

Current LDL-C value (pre-apheresis if applicable)

_____ mmol/L Date (DD/MM/YYYY) _____/_____/_____

Untreated LDL-C value (prior to treatment initiation)

_____ mmol/L Date (DD/MM/YYYY) _____/_____/_____

Total cholesterol value (pre-apheresis if applicable)

_____ mmol/L Date (DD/MM/YYYY) _____/_____/_____

Untreated total cholesterol value (prior to treatment initiation)

_____ mmol/L Date (DD/MM/YYYY) _____/_____/_____

Triglycerides value (pre-apheresis if applicable)

_____ mmol/L Date (DD/MM/YYYY) _____/_____/_____

Untreated triglycerides value (prior to treatment initiation)

_____ mmol/L Date (DD/MM/YYYY) _____/_____/_____

☐ Cutaneous or tendinous xanthoma Age of xanthoma onset _____

Family History

☐ Evidence of HeFH in both parents

Lipid-Lowering Treatments

	Treatment name	Dose	Current	Previous	Duration of treatment
☐ Statin	_____	_____	☐	☐	_____
☐ Ezetrol® (ezetimibe)		_____	☐	☐	_____
☐ PCSK9i	_____	_____	☐	☐	_____
☐ Juxtapid® (lomitapide)		_____	☐	☐	_____
☐ Other	_____	_____	☐	☐	_____

☐ Lipoprotein apheresis or ☐ Plasmapheresis ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

8. INFUSION SETTING AND ADMINISTRATION

Preferred Treatment Setting

☐ Out-patient clinic* ☐ Apheresis unit* * Provide contact name and phone number.

Contact name _____ Phone number _____

☐ Innomar clinic ☐ At home

9. EVKEEZA (EVINACUMAB FOR INJECTION) FOR INFUSION USE – PRESCRIPTION INFORMATION

The recommended dose for EVKEEZA is 15 mg/kg administered by intravenous (IV) infusions over 60 minutes every 4 weeks.
The rate of infusion may be slowed, interrupted, or discontinued if the patient develops any signs of adverse reactions, including infusion-associated symptoms.
EVKEEZA can be administered without regard to lipoprotein apheresis.

REQUIRED Patient's full name _____

Patient weight in kg _____

Date weight was taken on (DD/MM/YYYY) _____

Infusion fluid type (please select one):

☐ 0.9% sodium chloride injection

or

☐ 5% dextrose injection

Dose: 15 mg/kg IV every 4 weeks according to the weight of the day

Refills _____ Days' supply: 4 weeks

Special instructions/Indication: Administer by intravenous infusion over 60 minutes

If patient has already started treatment, EVKEEZA supply needed for scheduled treatment on (DD/MM/YYYY) _____/_____/_____

Supply format: EVKEEZA (evinacumab for injection) is supplied by 150 mg/mL concentrate for solution for infusion **(DIN: 02541769)**. Please see full Product Monograph at https://www.ultragenyx.ca/evkeezaproductmonograph for complete dosage and administration information. I authorize the Patient Support Program to be my designated agent to forward this prescription by fax, or other mode of delivery, to the pharmacy chosen by the above-named patient. This prescription represents the original prescription drug order. The patient's chosen pharmacy is the only intended recipient and there are no others.

By signing, I the prescriber consent to the processing of my personal information, such as my prescribing behaviour, which may be combined with the information of other prescribers to generate aggregated data to be used for statistical analysis, research, business planning purposes or to improve/make changes to the Program.

Prescriber Signature _____ **Prescriber Licence Number** _____ **Date** _____

Special instructions _____

Special precautions (e.g., allergies) _____

The prescriber assumes responsibility for monitoring lab values. The prescriber assumes responsibility for notifying UltraCare of any dosage changes or suspension of therapy.