Patient Support Program for PrEVKEEZA® (evinacumab for injection)

For Healthcare Providers (Sections 1–4 to be read and completed by healthcare provider)

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

1. PATIENT INFORMATION (Be sure to indicate their preferred contact method)

First, middle, last name _____

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

Health card number _____

Home phone _____ Work phone _____

Mobile phone _____ Email _____

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

Best time of day to contact patient _____

Street address _____

City _____

Province _____ Postal code _____

Caregiver name (first and last) _____

Relationship to patient _____ Caregiver phone _____

Preferred language: ☐ English ☐ French ☐ Other _____

☐ Consent to leave voicemail

2. 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 _____

3. PRESCRIBER INFORMATION

First name _____

Last name _____

Prescriber email _____

Prescriber phone _____ Fax _____

Office address _____

Office contact name _____

Office contact email _____

Office contact phone _____ Fax _____

4. 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 only lipoprotein apheresis.

REQUIRED Patient's full name _____

Patient weight in kg _____

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

Dose: Infuse 15 mg/kg IV every 4 weeks (use weight of the day). Provide 1 dose every 4 weeks. Repeat x _____

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

Infusion fluid type (please select one):

☐ 0.9% sodium chloride injection

or

☐ 5% dextrose injection

Refills _____

Preferred Treatment Setting

☐ Out-patient clinic ☐ Apheresis unit ☐ Innomar clinic ☐ At home ☐ Patient choice

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** _____

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

PLEASE FAX 2 PAGES TO: 1-833-592-2273 (CARE) **or EMAIL TO:** Ultracare@innomar-strategies.com

Toll-Free Line: 1-833-388-5872 (U-LTRA) | http://www.ultracaresupport.ca

Patient Support Program for PrEVKEEZA® (evinacumab for injection)

For Patients

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

(Section 5 to be read and completed by Patient or Patient's Authorized Representative)

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

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 _____

TEXT MESSAGE CONSENT:

☐ By checking this box, I consent to receive text messages from Ultragenyx Pharmaceutical, Inc. and its service providers about UltraCare Patient Services. Message frequency may vary; message/data rates may apply. Texts may not be secure. I may opt out as described in the Texting Terms: https://www.ultracaresupport.com/TC.pdf.

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, Innomar 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 equirements, 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.

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/).

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, and/or email) 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.

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