UltraCare™

UPON ENROLMENT, AN ULTRACARE CASE MANAGER WILL:

- Partner with and remain dedicated to your patient throughout the treatment journey
- Contact the patient or caregiver to review insurance coverage and support programs

GETTING STARTED: STEPS FOR SUCCESSFUL ENROLMENT IN ULTRACARE

Below are the most critical steps for ensuring complete and timely enrolment in UltraCare so your patient can benefit fully from the program's suite of support services.

OBTAIN PATIENT CONSENT[a]
The patient signature or verbal consent is required to allow third parties to share protected health information with Ultragenyx

SELECT PREFERRED PATIENT COMMUNICATION METHOD
Ask your patient and/or caregiver about how they will prefer to communicate with their UltraCare Case Manager and the best time to contact them

PRESCRIBER INFORMATION
Provide contact details

SPECIFY PRESCRIPTION FOR Pr CRYSVITA™ (Burosumab Injection)
Ensure the physician provides a wet signature and date, which are necessary to process the prescription

[a]If the patient wants to opt out of the patient consent section, inform the UltraCare team verbally on the phone or in writing to the email address below.

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. I authorize each of my physicians and pharmacists (including any specialty pharmacies and other health care providers), and each of my health insurers, to disclose my PI, including but not limited to medical records, information related to my medical condition and treatment, financial, lab values, insurance coverage information, my name, address and telephone number to Ultragenyx and its agents, contractors, and assignees who will 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, and work with third parties to provide community resources and referrals. I also authorize the collection, use and disclosure of information provided directly by me to the Program for legal obligations to report adverse drug events to health authorities and to monitor product complaints. I understand that Ultragenyx may contact me or my health care 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 and for research purposes including the identification of trends such as product utilization, adherence or outcomes.

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 that are different than those that apply in Canada. I understand I may refuse to sign this consent, in which case I cannot be enrolled in the Program and understand that my treatment and eligibility for health benefits, including my access to therapy, will not be otherwise conditioned on my signing this consent. I understand that revoking this consent will not affect the ability to use and disclose PI received prior to receipt of notification that I wish to discontinue my participation in the Program. I understand I may revoke this consent at any time verbally or by writing to the address listed at the top of this form. Once consent has been revoked, I understand no additional PI will be collected. I understand that my PI will not be used or disclosed for any purposes, unless permitted by law, other than the purposes stated herein.

I understand that I may contact the Program at any time to update or access my PI, modify, express a privacy-related concern, or inquire about the privacy practices of the Program.

Patient Signature_____ **Date**_____ **Parent/Guardian Signature** (if patient is minor)_____

IMPORTANT: If health care 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 health care 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.

CRYSVITA FOR XLH AND TIO

CRYSVITA has a simple dosing schedule. Below is the information on CRYSVITA dosages and dose adjustment schedules for patients with XLH or TIO.

X-LINKED HYPOPHOSPHATAEMIA (XLH) DOSING REGIMENS:

Pediatric XLH (6 month to < 1 year of age): For patients with a body weight ≥ 6 kg, starting dose regimen is 0.8 mg/kg of body weight, rounded down to the nearest 1 mg, administered every 2 weeks. The minimum starting dose is 5 mg.

Pediatric XLH (1 year to 18 years of age): Starting dose regimen is 0.8 mg/kg of body weight, rounded to the nearest 10 mg, administered every 2 weeks. The minimum starting dose is 10 mg up to a maximum dose of 90 mg.

Body Weight (kg)	10-14	15-18	19-31	32-43	44-56	57-68	69-80	81-93	94-105	106 and greater
Starting Dose (mg)	10	10	20	30	40	50	60	70	80	90
First Dose Increase to (mg)	15	20	30	40	60	70	90	90	90	90
Second Dose Increase to (mg)	20	30	40	60	80	90	90	90	90	90

Adult XLH (18 years of age and older): Starting dose regimen is 1 mg/kg of body weight, rounded to the nearest 10 mg up to a maximum dose of 90 mg, administered every 4 weeks.

TUMOR-INDUCED OSTEOMALACIA (TIO) DOSING REGIMEN:

Adult TIO (18 years of age and older): Starting dose is 0.5 mg/kg every 4 weeks, rounded to the nearest 10 mg. Dose may be increased up to 2 mg/kg, administered every 2 weeks.

	Starting Dose	First Dose Increase†	Second Dose Increase†	Third Dose Increase†	Fourth Dose Increase	Fifth Dose Increase (maximum dose)
If serum phosphorus 2 weeks post-dose adjustment is below lower limit of normal*	0.5 mg/kg every 4 weeks	Increase to 1 mg/kg every 4 weeks OR 0.5 mg/kg every 2 weeks	Increase to 1.5 mg/kg every 4 weeks‡ OR 0.75 mg/kg every 2 weeks	Increase to 2 mg/kg every 4 weeks‡ OR 1 mg/kg every 2 weeks	Increase to 1.5 mg/kg every 2 weeks	Increase to 2 mg/kg every 2 weeks

*Rounded to the nearest 10 mg. Do not adjust CRYSVITA more frequently than every 4 weeks.
†For those individuals not reaching a serum phosphorus greater than the lower limit of the normal range, physicians may consider dividing total dose administered every 4 weeks and administering every 2 weeks.
‡In patients with high body weight, if the calculated dose is greater than 180 mg every 4 weeks, move to a divided dose every 2 weeks.

You can report any suspected side effects associated with the use of health products to Health Canada at 1-866-234-2345 or http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/index-eng.php.
You may also report side effects to Ultragenyx at 1-833-388-5872 (U-LTRA).
Please see accompanying Product Monograph for a complete discussion of the risks associated with CRYSVITA.

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UltraCare™

Toll-free Line: 1-833-388-5872 (U-LTRA) | **Fax:** 1-833-592-2273 (CARE)
http://www.ultracaresupport.com | **Email:** Ultracare@innomar-strategies.com

Patient Enrolment Form

PATIENT INFORMATION: Be sure to choose your preferred contact method

First, Middle, Last Name _____

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

Street Address _____

City _____

Province _____ Postal Code _____

Home Phone (_____)_____ Work Phone (_____)_____

Mobile Phone (_____)_____ Best Time to Contact _____

Preferred Method of Contact: ☐ Home ☐ Work ☐ Mobile ☐ Email

Preferred Language: ☐ English ☐ French ☐ Other_____

Email _____

Caregiver Name (First and Last) _____

Relationship to Patient _____ Caregiver Phone (_____)_____

PRESCRIBER INFORMATION:

First Name _____

Last Name _____

Street Address _____

City _____

Province _____ Postal Code _____

Office Phone (_____)_____

Fax (_____)_____

Office Email _____

Office Contact Name/Title _____

Office Contact Phone (_____)_____

License # _____

CRYSVITA PRESCRIPTION INFORMATION:

Pediatric XLH (6 month to <1 year of age): Starting dose regimen for a body weight ≥ 6 kg is 0.8 mg/kg of body weight, rounded down to the nearest 1 mg, administered every 2 weeks. The minimum starting dose is 5 mg.

Pediatric XLH (1 year to 18 years of age): Starting dose regimen is 0.8 mg/kg of body weight, rounded to the nearest 10 mg, administered every 2 weeks. The minimum starting dose is 10 mg up to a maximum dose of 90 mg.

Adult XLH (18 years of age and older): Starting dose regimen is 1 mg/kg of body weight, rounded to the nearest 10 mg up to a maximum dose of 90 mg, administered every 4 weeks.

Adult TIO (18 years of age and older): Starting dose is 0.5 mg/kg of body weight, administered every 4 weeks, rounded to the nearest 10 mg, up to a maximum dose of 2 mg/kg, administered every 2 weeks.

Supplied as: 10 mg/mL single-dose vial, 20 mg/mL single-dose vial, 30 mg/mL single-dose vial.

Subcutaneous Injection Only.

CRYSVITA Prescription ☐ Familial hypophosphataemia ☐ Positive *PHEX* variant test ☐ Tumor-induced osteomalacia ☐ Other disorders of phosphorus metabolism ☐ Other _____

	Date Weight Taken	Patient Weight (in kg)	Initial Dose Prescribed	Total Calculated Dose	Frequency	Days Supply (Limit: 28 days)	Refills
☐ XLH ☐ TIO			☐ 0.8 mg/kg (Pediatric XLH) ☐ 1 mg/kg (Adult XLH) ☐ 0.5 mg/kg (Adult TIO)	☐ Round down to the nearest 1 mg and min dose is 5 mg ☐ Round to the nearest 10 mg and max dose is 90 mg	☐ Every 2 weeks (Pediatric XLH) ☐ Every 4 weeks (Adult XLH and TIO)		
		_____ (Weight (kg)) x _____ (Initial dose (mg/kg)) = _____ (Total dose (mg))					

Prescriber Signature _____ **Date** _____

Special Instructions _____

Special Precautions (eg, Allergies) _____

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

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