ultragenyx | 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 steps for ensuring complete and timely enrolment in UltraCare so your patient can benefit fully from the program.

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

2 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

3 PRESCRIBER INFORMATION
Provide contact details

4 SPECIFY PRESCRIPTION FOR [Pr]DOJOLVI® (triheptanoin)
Provide 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 on the phone or in writing by emailing ultracare@innomar-strategies.com.

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 healthcare 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 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 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.

1

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 a minor) _____

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.

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).

Patient Enrolment Form

2 PATIENT INFORMATION: Be sure to choose your preferred contact method

First, Middle, Last Name _____

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

Healthcard Number _____

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 (_____)_____

3 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 # _____

4

Has the patient previously been on MCT? ☐ Yes What was the dose? _____ ☐ No

5

Confirmed diagnosis of LC-FAOD by (check one)

☐ Disease-specific elevations of acylcarnitines on a newborn blood spot or in plasma.

☐ Enzyme activity assay (in cultured fibroblasts or lymphocytes) below the lower limit of the normal reference range for the reporting laboratory.

☐ Genetic testing demonstrating pathogenic mutation in a gene associated with long-chain fatty acid oxidation disorders.

Enzyme Deficiency Type ☐ CPTI ☐ CACT ☐ CPTII ☐ VLCAD ☐ TFP ☐ LCHAD

☐ Confirmed diagnosis of OTHER _____

6 PR DOJOLVI® (triheptanoin) oral liquid PRESCRIPTION INFORMATION:

For ☐ ORAL or ☐ ENTERAL FEEDING TUBE use only. TUBE TYPE: _____ FEEDS: BOLUS _____ or CONTINUOUS _____ Total Daily Caloric Intake _____

The recommended target daily dosage of DOJOLVI is up to 35% of the patient's total prescribed daily caloric intake (DCI), converted to mL, divided into at least four doses, administered at mealtimes or with snacks, at 3 to 4 hour intervals or as directed by the healthcare provider.

For patients not currently taking a medium-chain triglyceride (MCT) product

Initiate DOJOLVI at a total daily dosage of approximately 10% DCI divided into at least 4 times per day and increase to the recommended total daily dosage of up to 35% DCI over a period of 2 to 3 weeks.

For patients switching from another MCT product

Discontinue use of MCT products before starting DOJOLVI. Initiate DOJOLVI at the last tolerated dosage of MCT divided into at least 4 times per day. Increase the total daily dosage by approximately 5% DCI every 2 to 3 days until the target dosage of up to 35% DCI is achieved.

The total daily dosage (mL) of DOJOLVI is determined using the following calculation:

- Caloric value of DOJOLVI = 8.3 kcal/mL
- Round the total daily dosage to the nearest whole number
- Divide the total daily dosage into at least 4 approximately equal individual doses

$$\text{Total Daily Dose (\_\_\_\_mL)} = \frac{\text{Patients DCI (\_\_\_\_kcal) x Target \_\_\_\_\% dose of DCI}}{8.3\ \frac{\text{kcal}}{\text{mL}}\ \text{of DOJOLVI}}$$

☐ DOJOLVI Prescription (Titration)	Initial Total Daily Dose (mL) Rounded to Nearest Whole Number	÷ _____ Doses/Day = (at least 4)	Initial mL per Dose	Increase by _____ mL every _____ day(s) until reaching target _____ mL dose *Use the Prescription Directions field below to describe alternate desired dosing protocols*	Days Supply	Refills

Prescription Directions

☐ DOJOLVI Prescription (Maintenance)	Target Total Daily Dose (mL) Rounded to Nearest Whole Number	÷ _____ Doses/Day = (at least 4)	Days Supply	Refills

How Supplied: DOJOLVI (triheptanoin) oral liquid is supplied in **500 mL bottles (DIN: 02512556)**.

Please see full Product Monograph at www.ultragenyx.com/canada/medicines/dojolvi-product-monograph-CANADA/ for complete dosage and administration information.

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.

7 PLEASE SEND ME:

☐ Information on Ultragenyx educational events ☐ Invitation to participate in relevant Ultragenyx market research projects

Patient Signature _____ **Date** _____

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

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