

**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 \_\_\_\_\_ Street address \_\_\_\_\_  
Gender: ☐ Female ☐ Male ☐ Other DOB (DD/MM/YYYY) \_\_\_\_\_ City \_\_\_\_\_  
Health card number \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Caregiver name (first and last) \_\_\_\_\_  
Mobile phone \_\_\_\_\_ Email \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Caregiver phone \_\_\_\_\_  
Preferred method of contact: ☐ Home ☐ Work ☐ Mobile ☐ Email Preferred language: ☐ English ☐ French ☐ Other \_\_\_\_\_  
Best time of day to contact patient \_\_\_\_\_ ☐ Consent to leave voicemail

**2. Confirmed diagnosis of LC-FAOD (check one):** ☐ CPT I ☐ CACT ☐ CPT II ☐ VLCAD ☐ TFP ☐ LCHAD  
☐ Confirmed diagnosis of OTHER \_\_\_\_\_

**3. PRESCRIBER INFORMATION**

First name \_\_\_\_\_ Office address \_\_\_\_\_  
Last name \_\_\_\_\_ Office contact name \_\_\_\_\_  
Prescriber email \_\_\_\_\_ Office contact email \_\_\_\_\_  
Prescriber phone \_\_\_\_\_ Fax \_\_\_\_\_ Office contact phone \_\_\_\_\_ Fax \_\_\_\_\_

**4. DOJOLVI (TRIEPTANOIN) ORAL LIQUID - PRESCRIPTION INFORMATION****Prescription Information - Dojolvi 500 mL per Bottle (DIN: 02512556)**

- ☐ Oral  
☐ Enteral Feeding Tube use only.  
Tube Type: \_\_\_\_\_  
☐ Bolus Feed: \_\_\_\_\_  
☐ Continuous Feed: \_\_\_\_\_

☐ **Titration Rx**

Take \_\_\_\_\_ mL daily, divide quantity into \_\_\_\_\_ equal doses per day, increase total daily dose by \_\_\_\_\_ mL every \_\_\_\_\_ days until total daily dose equals \_\_\_\_\_.

Dispense: Dojolvi, \_\_\_\_\_ (Qty) X bottles of 500 mL. Repeat x \_\_\_\_\_

Notes: \_\_\_\_\_

☐ **Maintenance Rx**

Take \_\_\_\_\_ mL daily, divide quantity into \_\_\_\_\_ equal doses per day.

Dispense: Dojolvi, \_\_\_\_\_ (Qty) X bottles of 500 mL. Repeat x \_\_\_\_\_

Notes: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Special Precautions (e.g., Allergies): \_\_\_\_\_

Please see full Product Monograph at [www.ultragenyx.com/canada/medicines/dojolvi-product-monograph-CANADA/](http://www.ultragenyx.com/canada/medicines/dojolvi-product-monograph-CANADA/) 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](mailto:Ultracare@innomar-strategies.com)**

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

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**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](http://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.

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 DOJOLVI 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.

**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.

**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/](http://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/](http://www.ultragenyx.com/privacy-policy/)).

Print Patient or Authorized  
Patient Representative NameSignature of Patient or Authorized  
Patient Representative

Relationship to Patient

Date

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