Yorvipath®
palopegteriparatide

*Required field.

Fax: 1-888-436-0193
Phone: 1-844-44ASCENDIS (1-844-442-7236)
Email to: info@ascendissupport.com

A·S·A·P
ASCENDIS SIGNATURE ACCESS PROGRAM®

Please triage to ORSINI

Choose which best applies*:
- ❑ **Transitioning from calcium and active vitamin D**
- ❑ **Switching from PTH therapy:** _____
- ❑ **Continuing on YORVIPATH®**

Service(s) Requested

Check all that apply:
❑ Reimbursement support ❑ YORVIPATH device training ❑ A·S·A·P Bridge Support ❑ YORVIPATH Co-Pay Program enrollment
❑ Ascendis Patient Assistance Program

Patient Information

Patient name*: _____
Date of birth*: _ _ / _ _ / _ _ _ _ Sex*: ❑ M ❑ F ❑ Other
Primary language: ❑ English ❑ Spanish ❑ Other _____

Address*: _____
City*: _____
State*: _____ ZIP*: _____
Phone*: (_ _ _) _ _ _ - _ _ _ _
Email: orsini

Caregiver:
Name: _____
Relationship to patient: _____
Phone: (_ _ _) _ _ _ - _ _ _ _
Email: _____

Insurance Information

❑ Copies of front and back of primary medical insurance and pharmacy insurance (if applicable) cards are attached
❑ Patient has pharmacy insurance ❑ Patient is not insured

Primary medical insurance*: _____
Pharmacy/Rx insurance: _____
Member ID #*: _____ Group ID #: _____
Member name: _____
Phone*: (_ _ _) _ _ _ - _ _ _ _

Prior authorization (PA) submitted: ❑ Yes ❑ No
PA approval: ❑ Yes ❑ No
Date of PA approval: _ _ / _ _ / _ _ _ _
Reference number: _____

Diagnosis

Cause of hypoparathyroidism*:
❑ E89.2 Postprocedural hypoparathyroidism
Date of surgery: _ _ / _ _ / _ _ _ _

❑ E20 Hypoparathyroidism
❑ E20.0 Idiopathic hypoparathyroidism
❑ E20.8 Other hypoparathyroidism
❑ E20.9 Hypoparathyroidism, unspecified
❑ D82.1 Di George's syndrome
❑ Other: _____

Hypoparathyroidism Treatment History

Please confirm patient's serum calcium level*:
Serum calcium level: _____
Date: _ _ / _ _ / _ _ _ _
Within 2 weeks of first dose, confirm albumin-corrected serum calcium is ≥ 7.8 mg/dL.

❑ **My patient has hypoparathyroidism and it's not well controlled with calcium and active vitamin D alone**
Calcium dose (mg elemental calcium/day): _____ Date: _ _ / _ _ / _ _ _ _
Calcitriol daily dose (mcg/day): _____ Date: _ _ / _ _ / _ _ _ _
Serum 25(OH) vitamin D (ng/mL): _____ Date: _ _ / _ _ / _ _ _ _
PTH level (pg/mL): _____ Date: _ _ / _ _ / _ _ _ _

Prescriber Information

Prescriber name*: _____
Prescriber NPI #*: _____

Practice*: _____
Address*: _____
City*: _____
State*: _____ ZIP*: _____

Office contact*: _____
Office phone*: (_ _ _) _ _ _ - _ _ _ _
Office fax*: (_ _ _) _ _ _ - _ _ _ _
Office email*: _____

Preferred SP

❑ Panther ☑ Orsini

YORVIPATH Prescription and Physician Signature

The recommended starting dose is 18 mcg once daily.
YORVIPATH Prescription*: _____ mcg once daily
Quantity: 28 days
Refills: _____

Dose is only to be adjusted per physician's instruction and may be titrated to the appropriate dose in increments or decrements of 3 mcg/day with the daily dose ranging from 6 to 30 mcg/day. Injections are administered subcutaneously once daily to the abdomen or front of the thigh while rotating the injection site daily.

Concurrent medications: _____
Special precautions (eg, allergies): _____

PRESCRIBER AUTHORIZATION By signing below, I certify that: (a) I am a licensed practitioner, in good standing under applicable state law; (b) the information I have provided on this enrollment form is, to the best of my knowledge, true, complete, and accurate; and (c) I have obtained the necessary authorization from the patient, patient's caregiver, and/or legal representative to use, disclose, share, or otherwise release the above information, including the patient's protected health information ("PHI") for the purpose of providing patient assistance, including verifying insurance coverage, arranging training services, and evaluating patient's eligibility for alternate sources of funding. Further, I appoint the Ascendis Signature Access Program® ("A·S·A·P"), on my behalf, to convey this prescription to the dispensing pharmacy. I will immediately notify Ascendis Pharma if the above-named patient, individually or through their caregiver, and/or legal representative, revokes their consent. I give you permission to contact me, or the above-named patient, patient's caregiver, and/or legal representative.

❑ Dispense as written
Prescriber Signature*: _____
Date*: _ _ / _ _ / _ _ _ _

❑ Substitution allowed
Prescriber Signature: _____
Date: _ _ / _ _ / _ _ _ _

Injection Training

INJECTION TRAINING AUTHORIZATION A·S·A·P will provide my patient with training from a company-funded program on the proper self-administration of YORVIPATH. I will receive information on my patient's injection training via the fax number I provided above. This order is valid for 1 year. I will ensure my patient has received training by a healthcare professional prior to first use.

❑ **I do not wish to have training coordinated for my patient by A·S·A·P.** By checking this box and opting out of injection training, I acknowledge that I will assume responsibility and arrangements for YORVIPATH injection training for this patient.

ascendis pharma

Ascendis Pharma
Patient Authorization Form

By signing below, I authorize my healthcare providers, pharmacies, and health insurance plan (collectively, my "Health Team") to share my contact and health information (personal health information, or "PHI") with Ascendis Pharma Endocrinology, Inc., its affiliates, and their respective vendors (collectively, "Ascendis") in connection with my participation in the Ascendis Signature Access Program® (A·S·A·P), as detailed below. I authorize Ascendis to communicate with my Health Team about me and use my PHI in order to: (1) assess my eligibility for the A·S·A·P, co-pay support, or free drug programs; (2) provide me with benefits verification and reimbursement support; (3) provide me with devices or starter kits where appropriate and disease management or other educational materials, and (4) help evaluate and improve Ascendis products, services, and operations. I also authorize my Health Team to give me information about Ascendis products and services, understanding that it may receive financial remuneration for doing so. I understand that once my PHI is shared pursuant to this authorization form, it may no longer be protected by applicable privacy laws and could be re-disclosed, but that Ascendis intends to use and share my PHI only for the purposes described in this form or as otherwise permitted by law. I understand that I do not have to sign this form in order to receive medical treatment or health insurance coverage. However, if I do not sign this form, A·S·A·P will not be able to provide me with any assistance.

I understand that this authorization will remain in effect for five (5) years (unless a shorter time period is required by applicable law), unless I notify both my healthcare provider and Ascendis (by fax to 1-888-436-0193 or by mail to PO Box 1587, Jeffersonville, IN 47131) that I am revoking the authorization. I understand that if I revoke this authorization, that will not invalidate any use or disclosure of my PHI that took place before my notice of revocation was received by Ascendis. I understand I am entitled to receive a copy of this form after I have signed it below.

❑ By checking this box, I also consent to receive promotional or marketing communications from Ascendis and A·S·A·P. I understand that I can opt out of these communications at any time by contacting A·S·A·P at 1-844-442-7236.

Signature of Patient or Patient Representative	Printed name of Signer	Date
Printed name of Patient	Relationship to Patient	Date

If signed by patient representative, please indicate below the authority to act on behalf of the patient:

❑ Parent ❑ Legal Guardian ❑ Power of Attorney to make healthcare decisions

❑ Other: _____

For details about how we collect and use PHI, including applicable US privacy rights and notices under applicable state law, please visit https://ascendispharma.us/privacy-policy/.