Patient Enrollment Form for ROCTAVIAN® (valoctocogene roxaparvovec-rvox)

Please sign, date, and fax completed form to 1.888.863.3361.
To learn more about BioMarin RareConnections™ call **1.866.906.6100, hours M–F, 8 AM–8 PM (ET)**

ROCTAVIAN® (valoctocogene roxaparvovec-rvox)
Suspension for intravenous infusion

Please sign, date, and fax completed form to 1.888.863.3361

All required fields are purple and bolded

PATIENT

First Name	Middle Initial	**Last Name**	Suffix
Date of Birth (mm/dd/yyyy)	**Gender** ☐ Male ☐ Female ☐ Other		
Address			Floor/Suite/ Unit
City		**State**	**ZIP Code**
Primary Phone	Mobile Phone ☐ (same as primary)	**Email**	
Preferred Method of Contact ☐ Primary Phone ☐ Mobile Phone ☐ Email		**Preferred Language:** ☐ English ☐ Spanish ☐ Other language (please specify)	
Authorized Representative Name (if applicable)			Relationship to Patient
Phone		Email	

PRESCRIBER

First Name		**Last Name**	
Specialty		**NPI Number**	
State License Number	**Medicaid Number**	**Tax ID**	
Name of Institution/Practice			
Address			Floor/Suite/Unit
City		**State**	**ZIP Code**
Phone	**Fax**	**Email**	
Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email			
Primary Contact Name (if different from prescriber)			
Phone	Fax	Email	

INSURANCE

Provide copies of all medical and prescription cards — front and back

☐ Patient has no insurance

Primary Medical Insurance Name			**Insurance Phone**
Subscriber Name		**Relationship to Patient**	
Member ID	**Group**	**Plan Code**	
Prescription (PBM) Insurance Name			**Insurance Phone**
Subscriber Name			
Member ID	**RxBIN**	**RxPCN**	**RxGROUP**

Patient's Full Name	Date of birth (mm/dd/yyyy)

DIAGNOSIS / CLINICAL

ICD Code:

☐ D66.0 Hereditary factor VIII deficiency (please specify below)

— Classic hemophilia
— Deficiency factor VIII (with functional defect)
— Hemophilia NOS
— Hemophilia A

☐ Other diagnosis (Please specify) _____

Patient allergies

☐ NKDA ☐ Yes (please list)

Concurrent medications

INFUSION SITE

☐ Information provided in Prescriber section on first page

Infusion Site Name			
Address			**Floor/Suite/Unit**
City		**State**	**ZIP Code**
Infusion Site NPI		Infusion Site Contact (if available)	
Phone	Fax	Email	

PRESCRIPTION

Current weight (kg)	**Date weight measured (mm/dd/yyyy)**

ROCTAVIAN® (valoctocogene roxaparvovec-rvox) is provided in 10 mL vials containing an extractable volume of no less than 8 mL (16×10^{13} vg). Dose volume is based on body weight. To calculate a patient's dose in milliliters (mL), multiply body weight in kg by 3. The multiplication factor 3 represents the per-kilogram dose (6×10^{13} vg/kg) divided by the amount of vector genomes per mL of the ROCTAVIAN solution (2×10^{13} vg/mL). To calculate number of vials to be thawed, divide patient's dose volume in mL by 8 and round up to the next whole number of vials.

_____ (Patient's weight (kg)) **× 3 =** _____ (Dose (mL)) **/ 8 =** _____ (number of vials required)

Directions: Administer _____ ml as a single intravenous infusion per manufacturer product labeling	Refills: None
Dispense (number of vials): _____	NDC #: 68135-0927-48

PRODUCT COORDINATION

☐ Ship-to-site for product (if different from infusion site) ☐ (select if same as infusion site)

Ship-to-site Name			
Address			Floor/Suite/Unit
City		State	ZIP Code
Ship-to-site Contact Name	Phone	Fax	
Email	Shipping Instructions		

PRESCRIBER DECLARATION

Prescriber Declaration: By signing below, I, as the prescribing physician, certify that the information provided on this form was completed by me or at my direction. I understand and agree that, as the Prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me, as the Prescriber.

I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed ROCTAVIAN based on my professional judgment of medical necessity. I have informed my patient of the resources available in the BioMarin RareConnections program and have confirmed my patient's (or their respective caregiver's) consent to enroll in the program. I have obtained all required patient permissions and have complied with all federal and state laws with respect to disclosures and release of the provided information to BioMarin Pharmaceutical Inc., BioMarin RareConnections, and its affiliates, agents, and contractors (collectively, "BioMarin", as well as to or between other service providers such as laboratories and pharmacies, and for the purposes described herein by any means allowed under applicable law.

I understand that the information provided herein will be used for the purposes of BioMarin to investigate and verify patient's insurance and coverage benefits, to contact this patient to help obtain a signed patient consent form and/or to refer the patient to or contact the patient for purposes of enrollment in a patient education program, verify patient's insurance coverage benefits for ROCTAVIAN and any related services, to coordinate the dispensing and delivery of ROCTAVIAN (including transmitting the prescription to the appropriate pharmacies) utilizing the patient's benefit plan, assist in initiating or continuing therapy, provide prior authorization and appeals information, verify eligibility for a co-pay program, and identify additional financial resources, provide me and my patient with other education and support associated with ROCTAVIAN, and for BioMarin internal business purposes such as conducting quality control, data analysis, and gathering feedback to improve patient support and resources. By enrolling my commercially insured patient into the laboratory co-pay program, I acknowledge only those tests appropriate for determining eligibility and necessary follow-up for an FDA-approved use are eligible for co-pay support and that participation in the program is not contingent upon the recommendation, ordering, prescription, or purchase of any other product or service.

Prescriber's Signature **Date**