# Patient Enrollment Form for ROCTAVIAN™ (valoctocogene roxaparvovec-rvox)

Please sign, date, and fax completed form to 1.833.979.2207
To learn more about BioMarin RareConnections™ call **1.833.ROCTAVIAN** (1.833.762.8284), **hours M–F, 8 AM–8 PM (ET)**

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

**Please sign, date, and fax completed form to 1.833.979.2207**

**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 ($6 \times 10^{13}$ 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 ($6 \times 10^{13}$ vg/kg) divided by the amount of vector genomes per mL of the ROCTAVIAN solution ($2 \times 10^{13}$ 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.

_____ **× 3 =** _____ **/ 8 =** _____

Patient's weight (kg) | Dose (mL) | number of vials required

| **Directions:** Administer _____ ml as a single intravenous infusion per manufacturer product labeling | Refills: None |
|---|---|
| **Dose:** _____ vg **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. Please make a selection**

| Prescriber's Signature/Dispense as Written (no stamps or initials) Date | Prescriber's Signature/Substitution Permitted (no stamps or initials) Date |
|---|---|
| | |