Yorvipath®
palopegteriparatide

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®

- ❑ **New to YORVIPATH®**
- ❑ **Continuing on YORVIPATH**
- ❑ **Transitioning from oral calcium and active vitamin D**
- ❑ **Switching from PTH therapy:** ____________________

Service(s) Requested

Check all that apply:
❑ Reimbursement support ❑ Injection training ❑ A·S·A·P Bridge Support ❑ YORVIPATH Co-Pay Program enrollment
❑ Ascendis Patient Assistance Program ❑ *Extra Help* program assistance*

Patient Information

First name: ____________ M.I.: ________ Last name: ____________
Date of birth: _ _ / _ _ / _ _ _ _ Gender: ❑ M ❑ F ❑ Other
Street address: ____________ City: ________ State: ____ ZIP: ______
Mobile phone #: ____________ Home phone #: ____________ Email: ____________
Caregiver first name: ________ Last name: ________ Phone #: ________ Relationship to patient: ________

Insurance Information

Please attach copies of both sides of patient's insurance card(s). ❑ **Check if patient does not have insurance**
Primary Medical Insurance: ____________ Insurance phone #: ____________
Policy # / Member ID #: ____________ Group #: ____________
Policy holder's name: ____________ Relationship to patient: ____________
Primary Pharmacy Insurance: ____________ Pharmacy plan phone #: ____________
Policy ID #: ________ Group #: ________ Rx BIN #: ________ Rx PCN #: ________
Was a prior authorization already submitted? ❑ Yes ❑ No Date of submission: _ _ / _ _ / _ _ _ _

Diagnosis

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

❑ 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: _ _ / _ _ / _ _ _ _

❑ **My patient has hypoparathyroidism and it's not well controlled with calcium supplements and active vitamin D alone**
Calcium supplement dose (mg elemental calcium/day): ____________ Date: _ _ / _ _ / _ _ _ _
Calcitriol daily dose (mcg/day): ____________ Date: _ _ / _ _ / _ _ _ _
24-hour urine calcium (mg/24 h): ____________ Date: _ _ / _ _ / _ _ _ _
Serum 25(OH) vitamin D (ng/mL): ____________ Date: _ _ / _ _ / _ _ _ _

Prescriber Information

Prescriber name: ____________
Practice: ____________
DEA #: ____________
Prescriber Tax ID #: ____________

Prescriber NPI #: ____________
Address: ____________
City: ________ State: ________
ZIP: ____________

Office contact: ____________
Office phone #: ____________
Office fax: ____________
Office email: ____________

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 Prescriber certifies that he/she has obtained consent to release the patient's health information to A·S·A·P in conjunction with the services working solely on behalf of the patient for the purposes of seeking reimbursement through A·S·A·P; verifying insurance coverage; arranging for services; and evaluating the patient's eligibility for alternate sources of funding, patient support services, and materials and product fulfillment via Specialty Pharmacies. The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber. I authorize ancillary supplies, such as sharps containers, alcohol swabs, etc, to administer the therapy. For purposes of transmitting these prescriptions, I authorize Ascendis, its affiliates, business partners, and agents to forward as my agent for these limited purposes these prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

❑ 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 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.

*Medicare Part D low-income subsidy program.

ascendis pharma

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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/.

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