UREA CYCLE DISORDER PATIENT ENROLLMENT FORM INSTRUCTIONS

The Urea Cycle Disorder Patient Enrollment Form is required to initiate treatment with Horizon urea cycle disorder (UCD) medicines.

**Instructions:**

1. Complete all required patient information.
2. Complete all required insurance information for the patient and, if possible, attach a copy of the patient’s insurance card.
3. Complete the diagnosis and prescription information in its entirety; all fields are required. The patient’s healthcare provider should fill out this section.
4. Complete all required prescriber information, including the contact information for the practice or facility.
5. A signature is required from the patient’s healthcare provider.
6. Fax the completed form to Horizon Patient Services™ at 1-877-695-8304.
7. Check in with your patient to ensure he or she has completed the HIPAA Authorization Form. It must be completed and sent in to initiate support.
8. If you have any questions or comments, please contact Horizon Patient Services at 1-855-823-7878.
UREA CYCLE DISORDER PATIENT ENROLLMENT FORM

Please fax the completed form to 1-877-695-8304.
Email: horizonucd@horizontherapeutics.com
Phone: 1-855-823-7878
Please visit www.UCDSupport.com.

PATIENT INFORMATION (* indicates required field)

Patient Name*: ___________________________ DOB*: _____/_____/____ Gender*: □ Male □ Female
Address*: _______________________________ City*: ___________________ State*: ______ Zip Code*: __________________
Preferred Phone*: (_____) ___________________ Alternate Phone: (_____): __________________ Email*: __________________________
Caregiver/Alternate Contact Name: __________________________ Relationship: __________________________ Phone: (_____) __________________________
Preferred Contact: □ Patient □ Caregiver Preferred Type: □ Phone (Day) □ Phone (Evening) □ Email Preferred Language:

INSURANCE INFORMATION (* indicates required field) Please attach copies of insurance card(s), if available.

Primary Insurance Company*: __________________________ Phone: (_____) __________________________
Policy Type: □ Medicare □ Medicaid □ Commercial □ Other
Policy #*: __________________________ Group #: __________________________
Policyholder Name*: __________________________ Policyholder Name: __________________________
DOB: _____/_____/____ Relationship: __________________________ Phone: (_____) __________________________
Identification #: __________________________ Policy/Group #: __________________________
Policyholder Name: __________________________ Relationship: __________________________

DIAGNOSIS AND PRESCRIPTION INFORMATION (ALL fields required)

DIAGNOSIS:
□ Ornithine transcarbamylase deficiency/OTC (E72.4) □ Argininosuccinate lyase deficiency/ASL (E72.22)
□ Carbamoyl phosphate synthetase/CPS (E72.29) □ Citrullinemia/ASSD (E72.23)
□ Hyperammonemia-hyperornithinemia-homocitrullinuria syndrome/HHH (E72.4) □ Disorder of urea cycle metabolism, unspecified (E72.20)
□ Other diagnosis, ICD-10 __________ Please visit www.icd10data.com/Convert/270.6 for more information.

Patient Weight: ______ lb/kg (circle one) Patient Height: ______ in/cm (circle one) Date of Diagnosis (month/year): __________________
Current Nitrogen Scavenger: □ Sodium phenylbutyrate □ Sodium benzoate □ Sodium phenylbutyrate and sodium benzoate □ No nitrogen scavenger

PRESCRIPTION:
□ RAVICTI® (glycerol phenylbutyrate) Oral Liquid (mL) □ BUPHENYL® (sodium phenylbutyrate) Tablets □ BUPHENYL® (sodium phenylbutyrate) Powder (g)
Dose: __________ Doses/Day: __________ Total Daily Dose: __________ Days Supply: __________
Total Quantity: __________ = Refills: __________ Instructions: __________________

PRESCRIBER INFORMATION (* indicates required field)

First and Last Name*: __________________________ Credentials: __________________________
NPI #: __________________________ State License #: _______ State Issued: _______ Tax ID: __________________________ Specialty*: __________________________
Practice/Facility Name*: __________________________ Primary Contact Name: __________________________
Address*: __________________________ City*: __________________________ State*: ______ Zip Code*: __________________
Phone*: (_____) __________________________ Fax: (_____) __________________________ Prescriber Email: __________________________

Prescriber Acknowledgement: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I understand that Horizon Therapeutics plc and its affiliates and their respective employees or agents (collectively, "Horizon") will use this information to administer the Horizon Patient Services™ program (the "Program"), which provides assistance to patients in verifying insurance coverage for Horizon urea cycle disorder (UCD) medicines and assistance in initiating or continuing Horizon UCD medicines as prescribed. By my signature, I also certify that my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share Protected Health Information with Horizon for purposes of the Program. I appoint the Program, on my behalf, to proceed with services offered and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Horizon UCD medicines or any other Horizon product or service, for any other person, (b) my decision to prescribe Horizon UCD medicines was based solely on my professional determination of medical necessity, and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice.

State requirements: 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. By filling out this form, you automatically enroll your patient with a UCD into the Program, which includes assistance from Patient Access Managers (PAMs), unless the box below is checked.
Check here if you choose not to enroll this patient into the Program: □

Prescriber Name*: __________________________ Date: __________________________
Prescriber Signature*: __________________________
(Dispense as Written) (Substitution Allowed)

Please visit www.icd10data.com/Convert/270.6 for more information.
Please see the Important Safety Information for RAVICTI on page 4 and the Full Prescribing Information and Medication Guide available at RAVICTI.com. Please see the Important Safety Information for BUPHENYL on page 5, and visit horizontherapeutics.com/medicines/rare-diseases to download a copy of the BUPHENYL Full Prescribing Information and Patient Package Insert.
HIPAA Authorization

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address and telephone number to Horizon Therapeutics plc and its affiliates and their respective agents and representatives (collectively, “Horizon”), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, “Horizon Patient Services”) for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon Patient Services and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon Patient Services for determination); and (6) to send me marketing information related to my treatment or condition (or related products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon Patient Services otherwise as required or permitted by law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the program.

I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon Patient Services, 150 South Saunders Rd, Lake Forest, IL 60045, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration of remaining on this treatment or (b) 10 years from the date signed below. A photocopy of this Authorization will be treated in the same manner as the original.

Date: __________________________

Patient’s Printed Name: __________________________________________________________

Patient’s/Legally Authorized Representative’s Signature: ________________________________

Legally Authorized Representative’s Printed Name (if required): __________________________________

Patient’s/Legally Authorized Representative’s Home Address:

Street Address: __________________________________________________________

City: __________________________ State: _______ Zip Code: ________

Patient’s/Legally Authorized Representative’s Telephone: ____________________________  □ Home  □ Mobile

Patient’s/Legally Authorized Representative’s Email Address: ______________________________

Legally Authorized Representative’s Relationship to Patient: ☐ Spouse  ☐ Parent/Legal Guardian  ☐ Representative per Power of Attorney

Is there someone else with whom we may discuss your protected health information? ☐ No  ☐ Yes

Name: __________________________

Relationship to you: __________________________

Name: __________________________

Relationship to you: __________________________
What are possible side effects of RAVICTI?

RAVICTI may cause serious side effects, including:
• See “What is the most important safety information I should know about RAVICTI?”

The most common side effects of RAVICTI in adults include:
• diarrhea
• vomiting
• gas
• headache
• decreased appetite
• indigestion or heartburn

The most common side effects of RAVICTI in children 2 years to 17 years of age include:
• upper abdomen (stomach) pain
• decreased appetite
• headache
• vomiting

The most common side effects of RAVICTI in children 2 months to less than 2 years of age include:
• vomiting
• rash
• nausea
• reduced food intake

The most common side effects of RAVICTI in children less than 2 months of age include:
• vomiting
• rash
• nausea
• constipation
• diarrhea
• fever
• skin rash
• small round bumps on the skin

The most common side effects of RAVICTI in children less than 2 months of age include:
• vomiting
• rash
• decreased appetite and reduced food intake
• low red blood cell count (anemia)
• cough
• loss of too much body fluid (dehydration)
• too much acid in the blood (acidosis)
• high blood platelet count (thrombocythemia)

These are not all of the possible side effects of RAVICTI. Call your doctor for medical advice about side effects.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit http://www.fda.gov/medwatch or call 1-800-FDA-1088.

For additional important safety information, please see the Full Prescribing Information and Medication Guide available at RAVICTI.com and discuss with your doctor.
APPROVED USES and IMPORTANT SAFETY INFORMATION FOR BUPHENYL

What is BUPHENYL?
BUPHENYL (sodium phenylbutyrate) Tablets is a prescription medicine that can be taken by mouth and BUPHENYL (sodium phenylbutyrate) Powder is a prescription medicine that can be taken by mouth or feeding tube for the long-term management of high blood levels of ammonia (hyperammonemia) caused by a condition called urea cycle disorder (UCD).
BUPHENYL only treats high blood levels of ammonia in patients with the following enzyme deficiencies:
- Carbamylphosphate synthetase (CPS)
- Ornithine transcarbamylase (OTC)
- Argininosuccinic acid synthetase (AS)

BUPHENYL can be used in infants up to 28 days old who have a complete enzyme deficiency, and in patients 1 month of age and older who have a partial enzyme deficiency and have a history of brain damage from high blood levels of ammonia.
BUPHENYL must be used along with a low-protein diet and in some cases, dietary supplements.
BUPHENYL is not used to treat acute (severe) hyperammonemia, which is a medical emergency.

IMPORTANT SAFETY INFORMATION

What is the most important safety information I should know about BUPHENYL?
BUPHENYL may cause serious side effects, including:
Nervous system side effects (Neurotoxicity). The breakdown of BUPHENYL produces the byproduct phenylacetate (PAA), which may cause nervous system side effects.

Call your doctor or get medical help right away if you experience any of these symptoms while taking BUPHENYL:
- sleepiness
- weakness
- lightheadedness
- problems with memory
- worsening of numbness, tingling, or burning in your hands or feet
- change in taste
- problems with hearing
- confusion
- headache
- decreased appetite
- body odor
- absent or irregular periods in women

BUPHENYL may cause serious side effects, including:
- decreased appetite
- bad taste
- body odor
- absent or irregular periods in women

These are not all of the possible side effects of BUPHENYL. Call your doctor for medical advice about side effects.

For additional important safety information, see the Patient Package Insert available at hzndocs.com/BUPHENYL-Prescribing-Information.pdf and discuss with your doctor.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit http://www.fda.gov/medwatch or call 1-800-FDA-1088.