

HOW TO ENROLL YOUR PATIENT IN



Page 1: ENROLLMENT FORM

Select a service, complete the form, and have prescriber sign and date.

If no service option is selected, the patient will be enrolled in Full Access Services.

Service Requested (Select one)

Full Access Services
 Patient Assistance Program (PAP)
 VELTASSA Starter Supply Only

Additional instructions: _____

Full Access Services

- One 20-day free trial of VELTASSA® (patiomer)
- Insurance benefit investigation
- Prior authorization and appeals assistance
- Specialty pharmacy triage and coordination
- Co-pay and affordability assistance
- PAP eligibility review

Patient Assistance Program (PAP)

- PAP eligibility review
- Free VELTASSA to program-eligible uninsured and underinsured patients
- One 20-day free trial of VELTASSA

VELTASSA Starter Supply Only

- One 20-day free trial of VELTASSA
- Full Access Services available upon request
- Only sections 1, 3, and 4 on page 1 of Enrollment Form are required

Page 2: PRIVACY NOTICE & PATIENT AUTHORIZATION

Please have patient sign and date to enroll in requested Veltassa Konnect programs. Patient or patient's legal representative may also visit www.VELTASSAeconsent.com to provide authorization electronically. If patient signature is not available at the time of submission, Veltassa Konnect will follow up directly with the patient to try to obtain consent.

PRIVACY NOTICE & PATIENT AUTHORIZATION

I authorize Vifor Pharma, Inc. and companies and parties working with Vifor Pharma, Inc. to use and/or disclose my health information about my medical condition, records, treatment, and health plan for the purposes stated below. I also authorize my healthcare provider, my health plan, and my plan manager to disclose my health information to Vifor Pharma, Inc. for the purposes stated below. I understand this Authorization is voluntary. Vifor Pharma, Inc. cannot provide me services and information without it.

I authorize the use and/or disclosure of my health information for the following intended purposes only:

(1) for my enrollment, determination of my eligibility, and my participation in Veltassa Konnect and other related patient assistance program offerings; and for the administration of the program; (2) to help me communicate with me, my health plan, my provider, or my pharmacy about my medical care and insurance status; (3) to verify my insurance information; (4) to coordinate my prescription or medication through my healthcare provider and provide support for my medication as prescribed; (5) to refer me to alternative third party patient programs; and (6) to comply with law. I understand and agree that Vifor Pharma, Inc. may contact me by mail, email, phone, and/or text. Vifor Pharma, Inc. will generally leave voice messages with basic information. I authorize Vifor Pharma, Inc. to leave me voice messages with more detailed information about the reason for the call, which may contain more health information.

I understand that my refusal to sign this Authorization and/or choose not to return information or services from Vifor Pharma, Inc. will not affect my ability to receive or use my health plan, my provider, or my pharmacy for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. I may cancel or modify this Authorization at any time by writing to Vifor Pharma, Inc., 100 Cardinal Way, Redwood City, CA 94063. Canceling this Authorization will end my consent after the date Vifor Pharma, Inc. receives my letter but will not affect information previously disclosed pursuant to this Authorization. This Authorization shall be in effect for five (5) years from the date of my signature, unless a shorter period is required by law or is cancelled in writing. This Authorization may be extended upon written notification by either Vifor Pharma, Inc. or myself. Upon expiration of this Authorization, all information will be destroyed. I may receive a copy of this Authorization upon request. I certify that all the information I provide to Vifor Pharma, Inc. is complete and accurate to the best of my knowledge.

_____ *Jane Doe* _____ *Jane Doe* _____ *03/14/2021*

Patient or Patient's Legal Representative Name (Print) Patient or Patient's Legal Representative (Signature) Date

Describe representative's relationship to patient _____

Page 3 (optional): PATIENT MARKETING CONSENT

Please have patient fill out, sign, and date page 3 to enroll in optional patient marketing programs.

PATIENT MARKETING CONSENT

You may contact me by (Please mark and fill in all of the methods by which you would like to be contacted):

US Mail (Use address from page 1)

Email janedoe @ email.com

Phone (555) 555 - 5555

Text messaging mobile phone number (555) 555 - 5555

By providing your mobile phone number for texts or calls, you agree to marketing and nonmarketing messages from and on behalf of Vifor Pharma, Inc. using an automated telephone dialing system. This consent is not required to enroll in Vifor Pharma, Inc. services or purchase any products. Standard text messaging rates may apply.

_____ *Jane Doe* _____ *Jane Doe* _____ *03/14/2021*

Patient or Patient's Legal Representative Name (Print) Patient or Patient's Legal Representative (Signature) Date

SERVICE REQUESTED

(Select one)

-
- Full Access Services
-
- Patient Assistance Program (PAP)
-
- VELTASSA Starter Supply Only

Additional instructions: _____

1. Patient Information (Please provide physical address; no PO boxes.)

 Name (Last, First) _____
 Physical Address _____
 City _____ State _____ Zip _____
 Date of Birth ____/____/____ Male Female
 Primary Phone (____) ____ - ____ Best Time to Call _____

 Preferred Language _____
 Patient's Legal Representative Name _____
 (If applicable)
 Patient's Legal Representative Phone (____) ____ - ____
 Relationship to Patient _____

 Patient or patient's legal representative may also visit www.VELTASSAeconsent.com to provide authorization electronically.

2. Primary Medical Insurance Information (Please attach a copy [both sides] of medical and/or prescription drug insurance cards.)
 If patient is uninsured, please see and complete the PAP information at the bottom of this page.

 Primary Insurance Name _____
 Policy # _____
 Group # _____

 Primary Insurance Phone (____) ____ - ____
 Policyholder Name _____

3. Prescriber Information

 Prescriber Name _____
 Prescriber NPI _____
 Prescriber Tax ID _____
 State License # _____

 Treating Facility Name (e.g., name of practice, dialysis center, etc.) _____
 Treating Facility Address _____
 City _____ State _____ Zip _____
 Treating Facility Contact Name _____
 Phone (____) ____ - ____ Fax (____) ____ - ____

4. VELTASSA® (patiomer) for oral suspension prescription

 Diagnosis ICD-10 Code(s) Hyperkalemia E87.5 Other _____ Serum Potassium Level _____ Date of Lab _____

VELTASSA Starter Supply*: Upon prescriber's medical assessment of patient need, Veltassa Konnect will provide eligible new patients with a free trial offer of up to 20 days of VELTASSA.

-
- Yes, provide patient with a free supply of VELTASSA 8.4 g. Dissolve contents of one (1) packet into 1/3 cup of water and drink full amount once daily. Dispense 20-day supply. 0 refills.
-
-
- Ship to patient's address
-
- Ship to treating facility address

VELTASSA® (patiomer) for oral suspension prescription: Dissolve contents of one (1) packet into 1/3 cup of water and drink full amount. Take as directed.

-
- 8.4 g
-
- 16.8 g
-
- Once per day Dispense:
-
- 30-day supply
-
- Other _____ Refill _____ times
-
-
- 25.2 g
-
- Other _____
-
- 90-day supply

Prescriber Declaration

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed VELTASSA based on my judgment of medical necessity, and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Vifor Pharma, Inc. and companies and parties working with Vifor Pharma, Inc. to perform a preliminary assessment of insurance verification and determine patient eligibility for the Vifor Pharma, Inc. product program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received through the program.


Prescriber Signature _____ **Date** _____
 (No stamps; dispense as written)

Prescriber Signature _____ **Date** _____
 (No stamps; substitution permitted)

Patient Assistance Program (PAP) for uninsured applicants only

Annual pretax household income _____ Number of family members living in household _____

Uninsured PAP applicants are required to submit verification for all sources of household income at time of application, including a copy of one (1) of the following: most recent federal tax return, pay stub, W-2 statement, bank statement, or another source of income verification. This information will be used only to determine eligibility for the PAP. If you do not have one of the above-mentioned sources or if you have any change in your insurance or financial information, please call Veltassa Konnect at 1-844-870-7597.

*VELTASSA Starter Supply not contingent on purchase. No guarantee VELTASSA will be approved by patient's health plan.

PRIVACY NOTICE & PATIENT AUTHORIZATION

PATIENT SIGNATURE REQUIRED TO ENROLL IN VELTASSA KONNECT

By signing this Authorization, I authorize Vifor Pharma, Inc. and companies and parties working with Vifor Pharma, Inc. to use and/or disclose my health information about my medical condition, records, treatment, and health plan for the purposes stated below. I also authorize my healthcare providers, my health plans, and my pharmacies to disclose my health information to Vifor Pharma, Inc. for the purposes stated below. I understand this Authorization is voluntary, but Vifor Pharma, Inc. cannot provide me services and information without it.

Veltassa Konnect is a program sponsored by Vifor Pharma, Inc. that provides patient support and helps eligible patients access, afford, be informed about, and comply with their treatment as prescribed. Any free product provided through the program cannot be submitted for reimbursement and shall be used as prescribed. Once my health information has been disclosed, I understand that privacy laws may no longer protect the information. However, Vifor Pharma, Inc. agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law. I understand that certain parties, such as my pharmacy provider, may receive remuneration from Vifor Pharma, Inc. in connection with the activities described in this Authorization.

I authorize the use and/or disclosure of my health information for the following intended purposes only: (1) for my enrollment, determination of my eligibility, and my participation in Veltassa Konnect (and other related patient-assistance program offerings), and for the administration of the program; (2) to help communicate with me, my health plan, my provider, or my pharmacy about my medical care and insurance status; (3) to verify my insurance information; (4) to coordinate my prescription or medication through my healthcare provider and provide ongoing support for my treatment as prescribed; (5) to refer me to alternative third-party patient programs; and (6) to comply with law. I understand and agree that Vifor Pharma, Inc. may contact me by mail, email, phone, and/or text. Vifor Pharma, Inc. will generally leave voice messages with basic information. I authorize Vifor Pharma, Inc. to leave me voice messages with more detailed information about the reason for the call, which may contain more health information.

I understand that I may refuse to sign this Authorization and choose not to receive information or services from Vifor Pharma, Inc. I understand that my treatment (including with a Vifor Pharma, Inc. product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. I may cancel or modify this Authorization at any time by writing to Vifor Pharma, Inc., 100 Cardinal Way, Redwood City, CA 94063. Canceling this Authorization will end my consent after the date Vifor Pharma, Inc. receives my letter but will not affect information previously disclosed pursuant to this Authorization.

This Authorization shall be in effect for five (5) years from the date of my signature, unless a shorter period is required by law or it is canceled in writing. This Authorization may be extended upon written notification by either Vifor Pharma, Inc. or myself. Upon expiration of this Authorization, all information will be destroyed. I may receive a copy of this Authorization upon request. I certify that all the information I provide to Vifor Pharma, Inc. is complete and accurate to the best of my knowledge.



Patient or Patient's Legal Representative Name **(Print)**

Patient or Patient's Legal Representative **(Signature)**

Date

Describe representative's relationship to patient _____

PATIENT MARKETING CONSENT

I agree to receive additional disease and product information and to be contacted for my opinions as part of Vifor Pharma, Inc. and companies and parties working with Vifor Pharma, Inc. for marketing communications, which are separate from Veltassa Konnect (and other related patient-assistance program offerings).

These programs may include providing me with information or marketing materials about other products or services available from Vifor Pharma, Inc. and its affiliates, treatment reminders or education, or opportunities to participate in surveys or provide feedback. I understand my personally identifiable information (PII), including information about my use of Vifor Pharma, Inc. products, may be needed for me to be a part of these programs. I may choose to be contacted by mail, email, phone and/or text. I understand the use and disclosure of my PII will be limited to Vifor Pharma, Inc., its successors, and its agents, except as required by law. I agree to let Vifor Pharma, Inc., its successors, or its agents contact me in the future about these programs.

I understand the following:

- I can receive my medicine even if I do not sign this consent
- I can receive assistance from Veltassa Konnect even if I do not sign this consent
- This consent to enroll in these programs or receive marketing information is voluntary
- I may cancel my enrollment or consent to marketing at any time

You may contact me by (Please mark and fill in all of the methods by which you would like to be contacted):

US Mail (**Use address from page 1**) _____

Email _____ @ _____

Phone (_____) _____ - _____

Text messaging mobile phone number (_____) _____ - _____

By providing your mobile phone number for texts or calls, you agree to marketing and nonmarketing messages from and on behalf of Vifor Pharma, Inc., using an automated telephone dialing system. This consent is not required to enroll in Vifor Pharma, Inc. services or purchase any products. Standard text messaging rates may apply.

I understand that I may cancel or modify this Authorization at any time by writing to Vifor Pharma, Inc., 100 Cardinal Way, Redwood City, CA 94063. You may also contact us at 1-844-870-7597. For more information, you may view the Vifor Pharma, Inc. Privacy Policy at <https://www.viforpharma.com/en/about-vifor-pharma/data-privacy> or email privacy@viforpharma.com.

For California residents: I understand that, subject to certain restrictions, I may have the right to request a disclosure of what personal information is collected about me, and the right to request that Vifor Pharma, Inc. delete personal information that is collected about me, and to opt-out of the sale of personal information about me. Vifor Pharma, Inc. will not discriminate against you for exercising your California Consumer Privacy Act (CCPA) rights. Any requests for disclosure or deletion must be submitted in writing to Vifor Pharma, Inc. as listed in the Vifor Pharma, Inc. Privacy Policy.



Patient or Patient's Legal Representative Name (**Print**)



Patient or Patient's Legal Representative (**Signature**)



Date

