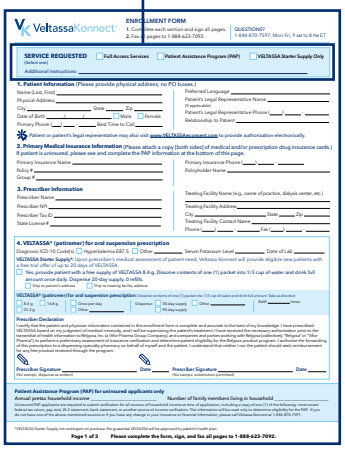
HOW TO ENROLL YOUR PATIENT IN VeltassaKonnect℠

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® (patiromer)
- 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.

Jane Doe — Patient or Patient's Legal Representative Name **(Print)**

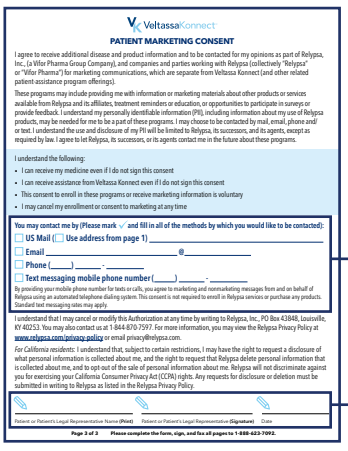
Jane Doe — Patient or Patient's Legal Representative **(Signature)**

03/14/2021 — 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.



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 Relypsa using an automated telephone dialing system. This consent is not required to enroll in Relypsa services or purchase any products. Standard text messaging rates may apply.

Jane Doe — Patient or Patient's Legal Representative Name **(Print)**

Jane Doe — Patient or Patient's Legal Representative **(Signature)**

03/14/2021 — Date

A version of this enrollment form that can be edited and saved is available online at **www.veltassa.com/supportservices/hcp/**.

VeltassaKonnect℠

ENROLLMENT FORM

1. Complete each section and sign all pages.
2. Fax all pages to 1-888-623-7092.

QUESTIONS?
1-844-870-7597, Mon-Fri, 9 AM to 8 PM ET

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® (patiromer) 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® (patiromer) 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 ☐ 25.2 g
☐ Once per day ☐ Other _____
Dispense: ☐ 30-day supply ☐ 90-day supply ☐ Other _____
Refill _____ times

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 Relypsa, Inc. (a Vifor Pharma Group Company), and companies and parties working with Relypsa (collectively "Relypsa" or "Vifor Pharma"), to perform a preliminary assessment of insurance verification and determine patient eligibility for the Relypsa 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.

VeltassaKonnect™

PRIVACY NOTICE & PATIENT AUTHORIZATION

PATIENT SIGNATURE REQUIRED TO ENROLL IN VELTASSA KONNECT

By signing this Authorization, I authorize Relypsa, Inc. (a Vifor Pharma Group Company), and companies and parties working with Relypsa (collectively "Relypsa" or "Vifor Pharma"), 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 Relypsa for the purposes stated below. I understand this Authorization is voluntary, but Relypsa cannot provide me services and information without it.

Veltassa Konnect is a program sponsored by Relypsa 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, Relypsa 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 Relypsa 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 Relypsa may contact me by mail, email, phone, and/or text. Relypsa will generally leave voice messages with basic information. I authorize Relypsa 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 Relypsa. I understand that my treatment (including with a Relypsa 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 Relypsa at Relypsa, Inc., PO Box 43848, Louisville, KY 40253. Canceling this Authorization will end my consent after the date Relypsa 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 Relypsa 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 Relypsa 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 _____

 Please complete the form, sign, and fax all pages to 1-888-623-7092.

VeltassaKonnect™

PATIENT MARKETING CONSENT

I agree to receive additional disease and product information and to be contacted for my opinions as part of Relypsa, Inc., (a Vifor Pharma Group Company), and companies and parties working with Relypsa (collectively "Relypsa" or "Vifor Pharma") 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 Relypsa 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 Relypsa 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 Relypsa, its successors, and its agents, except as required by law. I agree to let Relypsa, 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 Relypsa using an automated telephone dialing system. This consent is not required to enroll in Relypsa 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 Relypsa, Inc., PO Box 43848, Louisville, KY 40253. You may also contact us at 1-844-870-7597. For more information, you may view the Relypsa Privacy Policy at **www.relypsa.com/privacy-policy** or email privacy@relypsa.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 Relypsa delete personal information that is collected about me, and to opt-out of the sale of personal information about me. Relypsa 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 Relypsa as listed in the Relypsa Privacy Policy.



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

 Please complete the form, sign, and fax all pages to 1-888-623-7092.

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A Vifor Pharma Group Company

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