PHEBURANE® PATIENT ENROLLMENT FORM INSTRUCTIONS

The Patient Enrollment Form is required to initiate treatment with Pheburane® (sodium phenylbutyrate) oral pellets.

Healthcare Professionals Instructions:

1. Complete all required patient information.
2. Complete all required insurance information for the patient and attach copies of the front and back of the patient's medical and prescription insurance cards.
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 wet signature is required from the patient's healthcare provider.
6. Fax the completed form to either:
   Accredo Health Group, Inc at **1.888.454.8488**. Questions? Call **1.877.791.1171**
   CVS Specialty Pharmacy at 1.800.323.2455 Questions? Call **1.866.833.3752**
7. Check with your patient to ensure he or she has printed, signed, and dated the required Patient Authorization Form providing HIPAA authorization for Unik Support Program, in order to initiate patient support located on page 3.

DIAGNOSIS (REQUIRED)

Diagnosis including ICD-10 Code: ☐ Ornithine transcarbamylase deficiency/OTC (E72.4) ☐ Carbamylphosphate synthetase/CPS (E72.29)
☐ Citrullinemia/ASSD (E72.23) ☐ Disorder of urea cycle metabolism, unspecified (E72.20)
☐ Other diagnosis, ICD-10_____

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
DOB: ____ /____ /____ Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ ZIP: _____
Home Phone: (_____) _____ Mobile Phone: (_____) _____ Mobile Phone: (_____) _____
Email: _____
Leave Messages: ☐ Yes ☐ No Preferred time to call: ☐ AM ☐ PM Preferred Language: _____
Alternate Contact Name: _____ Relationship: _____
Alternate Contact Phone: _____ Alternate Contact Email: _____
Leave Messages with Alternate Contact: ☐ Yes ☐ No Preferred time to call: ☐ AM ☐ PM Preferred Language: _____

Please provide copies of front & back of all medical & prescription insurance cards

PHEBURANE® PATIENT ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

INSURANCE INFORMATION (Please provide copies of front & back of all medical & prescription insurance cards.)

Primary Insurance Company: _____

Phone: (_____) _____ Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other: _____

Policy #: _____ Group #: _____

Policyholder Name: _____

Relationship: _____ DOB: ____ /____ /____

Prescription Card: ☐ Yes ☐ No If Yes, Carrier: _____ Phone: (_____) _____

Identification #: _____

Policyholder Name: _____

Secondary Insurance Company: _____

Phone: (_____) _____ Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other: _____

Policy #: _____ Group #: _____

Policyholder Name: _____

Relationship: _____ DOB: ____ /____ /____

Policy/Group #: _____

Relationship: _____ DOB: ____ /____ /____

PRESCRIBER INFORMATION

Preferred Method of Contact ☐ Email ☐ Phone

First and Last Name: _____ Credentials: _____

NPI #: _____ State License #: _____ State Issued: _____ Tax ID: _____ Specialty: _____

Office/Clinic/Institution _____ Primary Contact Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: (_____) _____ Fax: (_____) _____ Primary Office Contact Email: _____

PRESCRIPTION INFORMATION Pheburane® (sodium phenylbutyrate) oral pellets (84 g/bottle)

Patient Weight: _____ ☐ lb ☐ kg (check one) Weight - Date Taken: _____

Patient Height: _____ ☐ in ☐ cm (check one) Height - Date Taken: _____ No Known Drug Allergies (NKDA): ☐

Complete Listing of all Concurrent Medications: _____ (attach a separate page if needed)

Allergies: _____ (attach a separate page if needed)

Take _____ grams by mouth _____ times per day. Total Daily Dose (in sodium phenylbutyrate) _____ Quantity _____ bottles Refills: _____
Maximum daily dose is 20 grams. Measure dose using only the calibrated dosing spoon provided in the packaging. Dosing spoon measures Pheburane® oral pellets as grams (g) of sodium phenylbutyrate. For oral administration only. Pheburane® must be taken with food (meal or snack). Pour oral pellets directly into dosing spoon to measure the dose. Patient: swallow pellets with a drink (water, fruit juices, or protein-free infant formula) OR sprinkle pellets onto a spoonful of apple sauce/carrot puree and swallow right away to prevent coating from starting to dissolve.

Instructions: _____

PRESCRIBER AUTHORIZATION

Prescriber Certification: 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 Medunik USA, Inc. and its affiliates and their respective employees or agents (collectively, "Medunik") will use this information to administer the Unik Support Program (the "Program"), which provides a wide array of patient-focused services, including providing logistical and non-medical treatment support and assistance in initiating or continuing Medunik's medicine as prescribed, and educating about the insurance process. By my signature, I also certify that (1) my patient or his/her personal representative has provided a signed HIPAA authorization that allows me to share protected health information with Medunik for purposes of the Program and (2) I have obtained the patient's authorization to release such information as may be required for Accredo Health Group, Inc. and other entities (or another party acting on behalf of Medunik) to assess insurance coverage for Medunik's medicine and assistance in initiating or continuing Medunik's medicine as prescribed. I appoint the Program, on my behalf, to proceed with services offered and to convey this prescription by facsimile only 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 Medunik's medicine or any other Medunik product or service, for any other person; (b) my decision to prescribe Medunik's medicine 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 Medunik may modify or terminate the Program at any time without notice. The completion and submission of coverage or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Medunik USA, Inc. makes no representation or guarantee concerning coverage or reimbursement for any item or service. **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 and signing this form, the enrollment process in the Unik Support Program has initiated; however, your patient must sign a Patient Authorization to complete enrollment in the Unik Support Program. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Medunik will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.**

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	**May Substitute / Product Selection Permitted /Substitution Permissible**
Prescriber's Signature:	Prescriber's Signature:
Date:	Date:
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**"	

PHEBURANE® PATIENT ENROLLMENT FORM

Patient Consent for Patient Information, Enrolling in Services, and Accessing Financial Support (referred to as "Patient 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 Unik Support Program, Inc. and its affiliates and their respective agents and representatives (collectively, "Medunik"), including third parties authorized by Medunik to administer drug support and to dispense drugs (collectively, "Unik Support Program") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (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 Unik Support Program and/or Medunik, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Unik Support Program for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or other 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 Medunik and/or Unik Support Program otherwise as required or permitted by law. I understand the pharmacies may receive a fee from Medunik 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 Medunik 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 Medunik 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 Medunik USA, 2 Research Way, Ste 1B, Princeton, NJ 08540. 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 a shorter expiration period is 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: _____

Legally Authorized Representative's Printed Name (if required): _____

Patient's/Legally Authorized Representative's Signature: _____

Patient's/Legally Authorized Representative's Home Address

Address: _____ City: _____ State: _____ ZIP: _____

Patient's/Legally Authorized Representative's Telephone: Phone: (_____) _____ ☐ 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: _____