kygevvi™
(doxecitine and doxribtimine)
Powder for Oral Solution
2 g/2 g per packet

ONWARD

Start Form for

KYGEVVI™ (doxecitine and doxribtimine)

Powder for Oral Solution

Instructions for Prescribers

To help a patient who has been prescribed KYGEVVI get started in ONWARD®, please follow these steps:

1. Complete the KYGEVVI Start Form, providing all required information.
2. Have your patient read and sign the Patient Authorization sections of the Start Form.
3. Fax the completed Start Form to 1-833-FAX-UCB1 (**1-833-329-8221**) or email it to **ucbonward@rxallcare.com**.

Instructions for Patients and Caregivers

1. Read and sign the Patient Authorization sections of the Start Form (page 5) to enroll in ONWARD.
2. If you would like us to communicate with you via email and/or text, make sure to check the appropriate consent boxes and provide your email address and/or mobile phone number.
3. You will receive a call from an ONWARD Care Coordinator to discuss the services being requested by you and/or your physician. Please note that when you receive this call, you may see “ONWARD” on your caller ID.

If you have any questions, please call us at 1-844-ONWARD1 (**1-844-669-2731**). A program associate is available to help you **Monday through Friday, 8 AM to 8 PM, Eastern Time**.

KYGEVVI™ (doxecitine and doxribtimine) Powder for Oral Solution Start Form

FAX: 1-833-FAX-UCB1 (1-833-329-8221)

ENROLL ONLINE: ONWARDhcp-enroll-KYGEVVI.com

QUESTIONS? CALL: 1-844-ONWARD1 (1-844-669-2731)

EMAIL: ucbonward@rxallcare.com

Step 1: Patient Information * Required field

☐ New to Therapy ☐ On Therapy

First Name* Jane | Middle Initial M | **Last Name*** Smith

Date of Birth* (MM/DD/YYYY) 08/13/2001 | **Phone Number*** 913-338-2234 ☐ Home ☑ Cell | Gender: M ☐ F ☐ Other ☐

Street Address* 1234 Carter Street | Apt#

City* Kansas | **State*** KS | **ZIP*** 66101 | Preferred Language: ☐ English ☐ Spanish ☐ Other

Email janemarysf381@gmail.com

☑ Please check here to authorize ONWARD Care Coordinators to leave detailed messages (which may include health information) on you/your Authorized Patient Representative's voicemail.

Authorized Patient Representative Information

By providing this information, you authorize ONWARD® to communicate with this person regarding your health condition and services provided by the program.

First Name | Last Name | Relationship to Patient

Phone ☐ Home ☐ Cell | Primary Point of Contact: ☐ Patient ☐ Authorized Patient Representative

Email

Step 2: Insurance Information * Required

NOTE: *You may attach copies of the front and back of the patient's insurance card(s) in lieu of completing this section.*

☐ Check here if patient does not have insurance	PRIMARY PHARMACY INSURANCE	PRIMARY MEDICAL INSURANCE	OTHER (e.g., Secondary)
INSURANCE PROVIDER	BCBS		
INSURANCE PHONE#	913-55-1234		
CARDHOLDER NAME	Jane M Smith		
RELATIONSHIP TO PATIENT	Self		
MEMBER ID	1234567-8904		
GROUP#	3456		
BIN#	1234		
PCN#	7891		

Step 3: Prescriber Information * Required field

Prescriber First Name* Jessica | **Prescriber Last Name*** Barry

Specialty Neurology | **NPI#*** 5678912345 | Tax ID# 1234567893

Supervising Physician | Supervising Physician NPI

Practice/Clinic Name Barry Medical

Address* 9087 Field Street

City Kansas City | State KS | ZIP 66401

Office Phone#* 913-902-2038 | Office Fax# 913-902-2037

Office Contact Name John | Office Contact Email john.doe@barrymedical.com

Office Contact Phone# Doe | Office Contact Communication Preference: ☑ Phone ☐ Email

STEP 4: Clinical Information * Required field

ICD-10 Diagnosis* ☑ E88.40 ☐ E88.49 ☐ E88.8 ☐ G71.3 ☐ Z15.89 ☐ Other _____

Does patient have confirmed biallelic mutations in the TK2 gene?* ☑ Yes ☐ No ☐ Unknown

Medical Allergies ☑ No allergies

STEP 5: KYGEVVI™ (doxecitine and doxribtimine) 2g/2g packet Prescription * Required field

Important information:

KYGEVVI is titrated based on tolerability to the recommended maintenance dosage level. The recommended initial dosage level of KYGEVVI is 260 mg/kg/day divided equally 3 times daily. The dosage should be titrated to the recommended intermediate dosage level of 520 mg/kg/day divided equally 3 times daily. The dosage should be further titrated to the recommended maintenance dosage level of 800 mg/kg/day divided equally 3 times daily. A minimum of 2 weeks at the current dosage level is recommended before titrating to the next dosage level.

- Please review with the patient/caregiver the Instruction for Use on how to prepare a one-day supply of KYGEVVI and administer each dose
- KYGEVVI prescription will be triaged to PANTHERx Rare
- Your patient will be contacted by PANTHERx to arrange for delivery of KYGEVVI
- Your patient will be provided the KYGEVVI powder packets and the mixing bottle for mixing and administration as appropriate

Patient First & Last Name* Jane Smith

Date of Birth* (MM/DD/YYYY) 08/13/2001

Patient Weight (kg)* 45

Date Weight Last Captured* 8/29/2025

DAILY DOSING INSTRUCTION* (Please select one of the options below)	ROUTE OF ADMINISTRATION* (Please select one of the options below)	DISPENSE DAYS SUPPLY* (Please select one of the options below)	REFILLS* (Please indicate any refills below)
☑ **Initiate with starting dose then titrate to maintenance dose** Administer 260 mg/kg/day divided equally 3 times daily for two weeks, then increase to 520 mg/kg/day divided equally 3 times daily for two weeks, then increase to 800 mg/kg/day divided equally 3 times daily thereafter. ☐ **Maintenance dose only**: 800mg/kg/day divided equally 3 times daily ☐ Other: _____	☑ Oral ☐ Feeding/ gastric tube	☑ 30 days ☐ Other: _____ days	☑ Refill for 1 year ☐ Other: _____
Note to the dispensing pharmacy: Provide the appropriate mixing bottle and any ancillary supplies as needed.			

Appropriate ancillary supplies will be dispensed with the medication unless otherwise indicated.

Physician Attestation and Signature

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to UCB, their affiliates, agents, representatives, business partners, and service providers (together "UCB") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to UCB so that UCB may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support UCB provides; and 5) I am licensed to prescribe the prescription medication identified in this form, the prescription complies with my state-specific prescribing requirements and I appoint UCB as my agent for the limited purposes of conveying this prescription by any means under applicable law only to the dispensing pharmacy. I understand that by signing this form, I am requesting support from UCB for Patients receiving KYGEVVI™. PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.

Print Prescriber First and Last Name* Jessica Barry

Prescriber Signature* 

Date* 4/22/2025

ATTN: If your local prescribing requirements call for submission of an electronic prescription, please submit to PANTHERx, NPI# 1659762524.

Patient and/or Caregiver Authorization

Please see next page for required HIPAA Authorization

☐ **PAP Consent (Required for the Patient Assistance Program):**

By checking here, applicants authorize ONWARD® PAP and its Administrators to obtain a consumer report. The consumer report, and the information derived from public and other sources, will be used to estimate income as part of the process to decide eligibility to receive free medication from the ONWARD PAP. Upon request, the ONWARD PAP will provide applicants with the name and address of the consumer reporting agency that provides the consumer report. For additional questions about eligibility, please call ONWARD at 1-844-669-2731 (1-844-ONWARD1).

☑ **Text Message Consent Language:**

By checking here, you agree to receive text messages from UCB ONWARD for patient support. Message and data rates may apply. Message frequency will vary based on need. Text "**HELP**" to **844669** for help. Text "**STOP**" to **844669** to cancel. If you have questions, call 1-844-669-2731 (1-844-ONWARD-1). For more information on how UCB will use your information, please view our privacy policy at www.ucb-usa.com/policy and our text messaging terms and conditions at www.ucbONWARD.com/Text-Terms-Conditions.

If giving consent, please provide your mobile number in Step 1: Patient Information to receive SMS communication.

☑ **Marketing Consent (Optional):**

By checking here & providing your information, you acknowledge you are a U.S. resident and give UCB and its business partners permission to send you information or contact you and/or your healthcare provider regarding your or your loved one's disease as well as information on other related treatments, products and services, and for marketing and informational purposes by phone, email, or mail. You understand that UCB or its business partners will not sell your name, address, email address, or any other information to another party for their own marketing use.

Please ensure an email address and phone number are provided in Step 1: Patient Information.

Patient Authorization to Use/Disclose Health Information (HIPAA Authorization) Required*

By signing this form, I hereby authorize each of my physicians, pharmacists (including any specialty pharmacy) that receives my prescription for a UCB medication, and other of my healthcare providers (together, "Providers") and each of my health insurers (together, "Insurers") to disclose information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and email addresses, telephone number, date of birth and Social Security Number (together, "Protected Health Information"), to UCB, Inc. and its agents, service providers, contractors and representatives (together, "UCB"), so that UCB may:

(i) enroll me in, and contact me about, UCB medication support programs.
(ii) provide me with educational materials, information, and services related to UCB medications.
(iii) verify, investigate, assist with, and coordinate my coverage for a UCB medication with my Insurers and Providers.
(iv) conduct market analyses/research or other commercial activity, including aggregating my Protected Health Information with other data for such analyses.
(v) assist with analysis related to quality, efficacy, and safety for UCB medication, and, in some cases, contact you to follow up on adverse events in order to obtain additional information.
(vi) de-identify my Protected Health Information for use for any purpose under applicable law.

I understand that once my Protected Health Information has been disclosed to UCB, federal privacy laws may no longer protect the information and it may be subject to re-disclosure. I understand that one or more Provider and/or Insurer may receive payment from UCB for disclosing my Protected Health Information for some or all of the purposes listed above.

I understand that I am not required to sign this Patient Authorization to Use/Disclose Health Information Authorization, and that if I decline to sign, that will not affect my treatment (including the receipt of UCB medication), payment for treatment, insurance enrollment, or eligibility for insurance benefits, but it may mean that I will not receive the other services described above.

I understand that I may cancel (revoke) this Authorization at any time by calling ONWARD at 1-844-669-2731 (1-844-ONWARD-1) or mailing a letter with my notice of withdrawal to ONWARD, 50 Bearfoot Road, Northborough, MA 01532.

UCB shall provide timely notification of my cancellation (revocation) to my Providers and Insurers. Once my Providers and Insurers receive and process the notice of cancellation (revocation) of this Authorization, my Providers and Insurers may no longer make disclosures of my Protected Health Information to UCB as permitted by this Authorization.

However, canceling this Authorization will not affect any action(s) taken by my Providers or Insurers based on this Authorization before receipt of my notice of cancellation. This authorization expires 5 years from the date it was signed, or such earlier date as required by applicable state law unless I cancel it beforehand. I understand that I have the right to receive a copy of this Authorization when it is signed.

I agree to this Patient Authorization Form.

Print Patient First and Last Name: Jane Smith

Date of Birth: 8/13/2001

(If applicable) Print Authorized Patient Representative First and Last Name:

Patient or Authorized Patient Representative Signature:

If authorized patient representative is signing, indicate the authorized patient representative's relationship to patient:

Relationship to Patient:

Signature:* 

Date:* 9/2/2025