

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**.

ONWARD® is provided as a service of UCB and is intended to support the appropriate use of UCB medicines. ONWARD may be amended or canceled at any time without notice. Some program and eligibility restrictions may apply.

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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*	Middle Initial	Last Name*
Date of Birth* (MM/DD/YYYY)	Phone Number*	<input type="checkbox"/> Home <input type="checkbox"/> Cell Gender: M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>
Street Address*		Apt#
City*	State*	ZIP*

Preferred Language: English Spanish Other

Email

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	<input type="checkbox"/> Home <input type="checkbox"/> Cell	Primary Point of Contact: <input type="checkbox"/> Patient <input type="checkbox"/> 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.

<input type="checkbox"/> Check here if patient does not have insurance	PRIMARY PHARMACY INSURANCE	PRIMARY MEDICAL INSURANCE	OTHER (e.g., Secondary)
INSURANCE PROVIDER			
INSURANCE PHONE#			
CARDHOLDER NAME			
RELATIONSHIP TO PATIENT			
MEMBER ID			
GROUP#			
BIN#			
PCN#			

Step 3: Prescriber Information * Required field

Prescriber First Name*	Prescriber Last Name*	
Specialty	Tax ID#	
Supervising Physician	Supervising Physician NPI	
Practice/Clinic Name		
Address*		
City	State	ZIP
Office Phone#*	Office Fax#	
Office Contact Name	Office Contact Email	
Office Contact Phone#	Office Contact Communication Preference: <input type="checkbox"/> Phone <input type="checkbox"/> 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™ (doxycitine 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*

Date of Birth* (MM/DD/YYYY)

Patient Weight (kg)*

Date Weight Last Captured*

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)
<input type="checkbox"/> 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.	<input type="checkbox"/> Oral <input type="checkbox"/> Feeding/gastric tube	<input type="checkbox"/> 30 days <input type="checkbox"/> Other: _____ days	<input type="checkbox"/> Refill for 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Maintenance dose only: 800mg/kg/day divided equally 3 times daily			
<input type="checkbox"/> 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*

Date*

Prescriber Signature*

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:

Date of Birth:

(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:*



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