Yorvipath® palopegteriparatide

Fax: 1-888-436-0193
Phone: 1-844-44ASCENDIS (1-844-442-7236)
Email to: info@ascendissupport.com

A·S·A·P ASCENDIS SIGNATURE ACCESS PROGRAM®

*Required field.

Choose which best applies*:
- ❑ **Transitioning from calcium and active vitamin D**
- ❑ **Switching from PTH therapy:** _____
- ❑ **Continuing on YORVIPATH®**

Service(s) Requested

Check all that apply:
❑ Reimbursement support ❑ YORVIPATH device training ❑ Ascendis Signature Access Program® (A·S·A·P) Bridge Support
❑ YORVIPATH Co-Pay Program enrollment ❑ Ascendis Patient Assistance Program

Patient Information

Patient name*: _____
Date of birth*: _ _ / _ _ / _ _ _ _ Sex*: ❑ M ❑ F ❑ Other
Primary language: ❑ English ❑ Spanish ❑ Other _____

Address*: _____
City*: _____
State*: _____ ZIP*: _____
Phone*: (_ _ _) _ _ _ - _ _ _ _
Email: _____

Caregiver:
Name: _____
Relationship to patient: _____
Phone: (_ _ _) _ _ _ - _ _ _ _
Email: _____

Insurance Information

❑ Copies of front and back of primary medical insurance and pharmacy insurance (if applicable) cards are attached
❑ Patient has pharmacy insurance ❑ Patient is not insured

Primary medical insurance*: _____
Pharmacy/Rx insurance: _____
Member ID #*: _____ Group ID #: _____
Member name: _____
Phone*: (_ _ _) _ _ _ - _ _ _ _

Prior authorization (PA) submitted: ❑ Yes ❑ No
PA approval: ❑ Yes ❑ No
Date of PA approval: _ _ / _ _ / _ _ _ _
Reference number: _____

Diagnosis

Cause of hypoparathyroidism*:
❑ E89.2 Postprocedural hypoparathyroidism
Date of surgery: _ _ / _ _ / _ _ _ _

❑ E20 Hypoparathyroidism
❑ E20.0 Idiopathic hypoparathyroidism
❑ E20.8 Other hypoparathyroidism
❑ E20.9 Hypoparathyroidism, unspecified
❑ D82.1 Di George's syndrome
❑ Other: _____

Hypoparathyroidism Treatment History

Please confirm patient's serum calcium level*:
Serum calcium level: _____
Date: _ _ / _ _ / _ _ _ _
Within 2 weeks of first dose, confirm albumin-corrected serum calcium is ≥ 7.8 mg/dL.

❑ **My patient has hypoparathyroidism and it's not well controlled with calcium and active vitamin D alone**
Calcium dose (mg elemental calcium/day): _____ Date: _ _ / _ _ / _ _ _ _
Calcitriol daily dose (mcg/day): _____ Date: _ _ / _ _ / _ _ _ _
Serum 25(OH) vitamin D (ng/mL): _____ Date: _ _ / _ _ / _ _ _ _
PTH level (pg/mL): _____ Date: _ _ / _ _ / _ _ _ _

Prescriber Information

Prescriber name*: _____
Prescriber NPI #*: _____

Practice*: _____
Address*: _____
City*: _____
State*: _____ ZIP*: _____

Office contact*: _____
Office phone*: (_ _ _) _ _ _ - _ _ _ _
Office fax*: (_ _ _) _ _ _ - _ _ _ _
Office email*: _____

Preferred SP

❑ PANTHERx ❑ Orsini

YORVIPATH Prescription and Physician Signature

The recommended starting dose is 18 mcg once daily.
YORVIPATH Prescription*: _____ mcg once daily
Quantity: 28 days
Refills: _____

Dose is only to be adjusted per physician's instruction and may be titrated to the appropriate dose in increments or decrements of 3 mcg/day with the daily dose ranging from 6 to 30 mcg/day. Injections are administered subcutaneously once daily to the abdomen or front of the thigh while rotating the injection site daily.

Concurrent medications: _____
Special precautions (eg, allergies): _____

PRESCRIBER AUTHORIZATION I certify that the information provided above is, to the best of my knowledge current, complete, and accurate and the therapy I have prescribed above is medically necessary for this patient and patient's records contain supporting documentation that substantiates the utilization and medical necessity of the therapy. I have discussed A·S·A·P with my patient and my patient would like to be screened for eligibility for A·S·A·P and provided, if applicable, any services under A·S·A·P. I will comply with my own state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language. I understand that noncompliance with state-specific requirements could result in outreach to the prescriber. I authorize the provision to patient of ancillary supplies, such as sharps containers and alcohol swabs, to administer the therapy. I acknowledge that the prescription may only be filled by a limited number of specialty pharmacies and prescriber authorizes Ascendis and those acting on its behalf to transmit the prescription electronically, by facsimile, or by mail to the appropriate dispensing specialty pharmacy.

❑ Dispense as written
Prescriber Signature*: _____
Date*: _ _ / _ _ / _ _ _ _

❑ Substitution allowed
Prescriber Signature: _____
Date: _ _ / _ _ / _ _ _ _

Injection Training

INJECTION TRAINING AUTHORIZATION A·S·A·P will provide my patient with training from a company-funded program on the proper self-administration of YORVIPATH. I will receive information on my patient's injection training via the fax number I provided above. This order is valid for 1 year. I will ensure my patient has received training by a healthcare professional prior to first use.

❑ **I do not wish to have training coordinated for my patient by A·S·A·P.** By checking this box and opting out of injection training, I acknowledge that I will assume responsibility and arrangements for YORVIPATH injection training for this patient.

ascendis pharma

© November 2025 Ascendis Pharma Endocrinology, Inc. All rights reserved. YORVIPATH®, Ascendis Signature Access Program®, Ascendis®, the Ascendis Pharma logo and the company logo are registered trademarks owned by the Ascendis Pharma Group. US-COMMPTH-2500151 11/25