

*Required field.

PATIENT ENROLLMENT FORM

Patient support services requested:

☐ YUWEL FastStart ☐ Injection training support ☐ Ascendis Patient Assistance Program ☐ A-S-A-P Bridge Support

1-PATIENT
INFORMATION

Patient name*: _____
Date of birth*: __/__/____ Sex*: ☐ M ☐ F
Address*: _____
City*: _____ State*: ____ ZIP*: _____
Primary language: _____

Parent/Guardian #1:
Name*: _____
Relationship to patient*: _____
Phone*: (____) ____-____
Email: _____

Parent/Guardian #2:
Name: _____
Relationship to patient: _____
Phone: (____) ____-____
Email: _____

2-INSURANCE

☐ 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: _____

3-DIAGNOSIS

☐ Please check box to confirm ICD-10 diagnosis: **Q77.4 Achondroplasia***

ICD-10 CM Q77.4 is used for achondroplasia; YUWEL is only indicated for increasing linear growth in pediatric patients with achondroplasia and open growth plates (epiphyses).

4-MEDICAL
ASSESSMENT

Please provide the following details:

Current weight*: _____ kg

Date of measure*: __/__/____

Height: _____ cm

Date of measure: __/__/____

Known drug allergies: ☐ Yes ☐ No

If yes, list allergies*: _____

Concurrent medications*: _____

Confirmed FGFR3 mutation

Date of test: __/__/____

Open epiphyses*: ☐ Yes ☐ No

X-ray date: __/__/____

5-PRESCRIBER
INFORMATION

Prescriber name*: _____
Practice*: _____
DEA #: _____
Prescriber NPI #: _____

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

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

6-PRESCRIPTION/
DOSAGE

YUWEL weekly subcutaneous dose and injection volume (please select the weekly dose/injection volume based on the patient's body weight)*:

1.3 mg vial (NDC 73362-201-01)

☐ **8.0 to 9.9 kg**; 0.88 mg (0.40 mL) SC weekly
☐ **10.0 to 13.4 kg**; 1.2 mg (0.55 mL) SC weekly

2.8 mg vial (NDC 73362-202-01)

☐ **13.5 to 17.5 kg**; 1.6 mg (0.35 mL) SC weekly
☐ **17.6 to 23.0 kg**; 2.1 mg (0.45 mL) SC weekly
☐ **23.1 to 30.5 kg**; 2.8 mg (0.60 mL) SC weekly

5.5 mg vial (NDC 73362-203-01)

☐ **30.6 to 41.2 kg**; 3.6 mg (0.65 mL) SC weekly
☐ **41.3 to 55.9 kg**; 5.0 mg (0.90 mL) SC weekly
☐ **56.0 to 73.5 kg**; 6.6 mg (2 x 0.60 mL) SC weekly
☐ **73.6 to 90.0 kg**; 8.8 mg (2 x 0.80 mL) SC weekly

Month(s) supply: _____ Refills: _____

7-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: __/__/____

8-TRAINING SUPPORT
AUTHORIZATION

Injection Training Support Authorization A-S-A-P will provide my patient/patient's caregiver with training on the proper administration of YUWEL. I am requesting A-S-A-P to coordinate YUWEL injection training support for my patient/patient's caregiver. I will receive information on the injection training support that my patient/patient's caregiver has received via the fax number I provided above. This order is valid for 1 year.

☐ **I do not wish to have my patient/patient caregiver trained by A-S-A-P.** By checking this box and opting out of injection training support, I acknowledge that I will assume responsibility and arrangements for YUWEL injection training for this patient/patient caregiver.

YUWEL will be dispensed solely through AnovoRx.

FGFR3 = fibroblast growth factor receptor-3; SC = subcutaneous.

*This form cannot be processed without prescriber's signature.