ENROLL YOUR PATIENT IN THE

VeltassaKonnect℠ PATIENT ASSISTANCE PROGRAM

1. Complete each section and sign all pages. **2.** Fax all pages to 1-888-623-7092. | QUESTIONS? 1-844-870-7597, Mon-Fri, 9 AM to 8 PM ET

1. Patient Information (Please provide physical address; no PO boxes.)

Name (Last, First) _____

Physical Address _____

City _____ State _____ Zip _____

Date of Birth ____/____/____ ☐ Male ☐ Female

Primary Phone (___) ____ - _____ Best Time to Call _____

Preferred Language _____

Patient's Legal Representative Name _____
(if applicable)

Patient's Legal Representative Phone (____) _____ - _____

Relationship to Patient _____

Annual pretax household income _____ Number of family members living in household _____

Uninsured PAP applicants are required to submit verification for all sources of household income at time of application, including a copy of 1 of the following: most recent federal tax return, pay stub, W-2 statement, bank statement, or another source of income verification. This information will be used only to determine eligibility for the PAP. If you do not have 1 of the above-mentioned sources or if you have any change in your insurance or financial information, please call Veltassa Konnect at 1-844-870-7597.

Patient or patient's legal representative may also visit www.VELTASSAeconsent.com to provide authorization electronically.

2. Primary Medical Insurance Information (Please attach a copy [both sides] of medical and/or prescription drug insurance cards.)

If patient is uninsured, please see and complete the PAP information at the bottom of this page.

Primary Insurance Name _____

Policy # _____

Group # _____

Primary Insurance Phone (____) _____ - _____

Policyholder Name _____

3. Prescriber Information

Prescriber Name _____

Prescriber NPI _____

Prescriber Tax ID _____

State License # _____

Treating Facility Name (eg, name of practice, dialysis center, etc)
_____

Treating Facility Address _____

City _____ State _____ Zip _____

Treating Facility Contact Name _____

Phone (____) _____ - _____ Fax (____) _____ - _____

4. VELTASSA® (patiromer) for oral suspension prescription*

Diagnosis ICD-10 Code(s) ☐ Hyperkalemia E87.5 Serum Potassium Level _____ Date of Lab _____

☐ Ship to patient's address ☐ Ship to treating facility address

VELTASSA® (patiromer) for oral suspension prescription: Mix contents of 1 packet into 1/3 cup of water, other beverages, or soft food (eg, apple sauce, yogurt, pudding) and consume full amount. A minimum volume of 45 mL (3 Tablespoons) can be used to prepare doses up to and including 4 grams patiromer. Take as directed.

☐ 8.4 g ☐ 16.8 g ☐ 25.2g (16.8 + 8.4g)
☐ 4g (4 x 1.0g) Pediatric (12-17yrs)

☐ Once daily
☐ Other _____

Dispense: ☐ 30-day supply ☐ Other _____
☐ 90-day supply

Refill _____ times

Prescriber Declaration

I certify that the patient and physician information contained in this enrollment form are complete and accurate to the best of my knowledge. I have provided the attached privacy notice and authorization form to the patient and have prescribed VELTASSA based on my judgment of medical necessity, and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to companies and parties working with Vifor Pharma, Inc. to perform a preliminary assessment of insurance verification and determine patient eligibility for the Vifor Pharma, Inc. product program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy. I understand that neither I nor the patient should seek reimbursement for any free product received through the program.

Prescriber Signature _____ **Date** _____ ☐ **Dispense as written**
(no stamps; substitution permitted)

*No guarantee VELTASSA will be approved by patient's health plan

VeltassaKonnect™

PRIVACY NOTICE & PATIENT AUTHORIZATION

PATIENT SIGNATURE REQUIRED TO ENROLL IN VELTASSA KONNECT

Veltassa Konnect is a service sponsored by Vifor Pharma, Inc. that provides patient support and helps eligible patients access, afford, be informed about, and comply with their treatment as prescribed. Any free product provided through the program cannot be submitted for reimbursement and shall be used as prescribed.

By signing this Authorization, I authorize Vifor Pharma, Inc. and companies and parties working with Vifor Pharma, Inc. to use and/or disclose health information about my medical condition, records, treatment, and health plan for the purposes stated below. I also authorize my healthcare providers, my health plans, and my pharmacies to disclose my health information to Vifor Pharma, Inc. and companies and parties working with Vifor Pharma, Inc. for the purposes stated below. I understand this Authorization is voluntary, but Vifor Pharma, Inc. cannot provide me services and information without it.

Once my health information has been disclosed, I understand that privacy laws may no longer protect the information. However, Vifor Pharma, Inc. agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law. I understand that certain parties may receive remuneration from Vifor Pharma, Inc. in connection with the activities described in this Authorization.

I authorize the use and/or disclosure of my health information for the following intended purposes only: (1) for my enrollment, determination of my eligibility, my participation in the Veltassa Konnect Patient Assistance Program, and the administration of the program; (2) to help communicate with me, my health plan, or my provider about my medical care and insurance status; (3) to verify my insurance information; (4) to coordinate my prescription or medication through my healthcare provider for my treatment as prescribed; (5) to refer me to alternative third-party patient programs; and (6) to comply with law.

I understand that I may refuse to sign this Authorization and choose not to receive information or services from Vifor Pharma, Inc. I understand that my treatment (including with a Vifor Pharma, Inc. product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. I may cancel or modify this Authorization at any time by writing to Vifor Pharma, Inc., 1000 First Ave, Suite 300, King of Prussia, PA 19406. Canceling this Authorization will end my consent after the date Vifor Pharma, Inc. receives my letter but will not affect information previously disclosed pursuant to this Authorization.

This Authorization shall be in effect for 5 years from the date of my signature, unless a shorter period is required by law or it is canceled in writing. This Authorization may be extended upon written notification by either Vifor Pharma, Inc. or me. Upon expiration of this Authorization, all information will be destroyed. I may receive a copy of this Authorization upon request. I certify that all the information I provide to Vifor Pharma, Inc. is complete and accurate to the best of my knowledge.



Patient, Patient's Parent, Guardian or Legal Representative ***(Print)*** Patient, Patient's Parent, Guardian or Legal Representative ***(Signature)*** Date

Describe representative's relationship to patient _____

 Please complete the form, sign, and fax both pages to 1-888-623-7092.

CSL Vifor

Veltassa® (patiromer) for oral suspension