UPON ENROLMENT, AN ULTRACARE® CASE MANAGER WILL:

- Partner with and remain dedicated to the patient throughout their treatment journey
- Contact the patient or caregiver to review insurance coverage and support programs

For Patients

PATIENT CONSENT TO COLLECT, USE, AND SHARE PERSONAL INFORMATION (PI) AND SIGNATURE

(Sections 1–4 to be read and completed by Patient or Patient's Authorized Representative)

The purpose of this form is to permit HoFH patients who have been prescribed EVKEEZA® (evinacumab for injection) to receive information and support ("Patient Support") from UltraCare, its affiliates, representatives, agents, and contractors. UltraCare provides Patient Support to eligible patients who have been prescribed EVKEEZA. This includes: (1) providing reimbursement and financial support to eligible patients (such as investigating your insurance coverage and reviewing eligibility for financial assistance); (2) working with you and your provider to fill your prescription; (3) providing you with disease- and medication-related educational resources and communications; and (4) coordinating EVKEEZA infusions.

The UltraCare Program ("Program") is sponsored by Ultragenyx Pharmaceutical, Inc. ("Ultragenyx") and administered by Innomar on behalf of Ultragenyx.

Please read this form carefully and ask any questions that you may have before signing.

1. PATIENT INFORMATION (Be sure to choose your preferred contact method)

First, middle, last name _____

Gender ☐ Female ☐ Male ☐ Other DOB (DD/MM/YYYY) _____

Health card number _____

Home phone (_____)_____ Work phone (_____)_____

Mobile phone (_____)_____ Best time to contact _____

Preferred method of contact: ☐ Home ☐ Work ☐ Mobile ☐ Email

Preferred language: ☐ English ☐ French ☐ Other _____

Street address _____

City _____

Province _____ Postal code _____

Email _____

Caregiver name (first and last) _____

Relationship to patient _____ Caregiver phone (_____)_____

2. AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

By signing below, I authorize my healthcare providers, including my physicians and pharmacies ("My Providers") and my health insurance plan ("My Plan") to share my medical information (such as information about my diagnosis, prescriptions, and treatment) and my insurance information ("My Information") with UltraCare so that UltraCare can provide Patient Support. I authorize My Providers to use My Information to provide me with certain offerings related to my medication and treatment. I understand that once My Information has been disclosed, federal privacy laws may no longer protect the information. However, I understand that UltraCare agrees to protect My Information by using and disclosing it only for purposes described in this Authorization or as required by law or regulations. I understand that Innomar deploys security practices that include the development of internal controls that restrict both logical and physical access to its systems to appropriate authorized personnel. As a component of Data Security, Innomar invests in data encryption per industry regulations and standards. Data is encrypted across all company assets, including servers and workstations. I understand that these efforts will be made to keep my PI confidential.

I understand that I may refuse to sign this Authorization, and that my treatment, insurance enrolment, and eligibility for insurance benefits are not conditioned upon signing this Authorization. I also understand, however, that refusing to sign this Authorization means that I may not participate in UltraCare and may not be able to take advantage of other offerings by UltraCare. I may cancel or revoke this Authorization at any time by letting UltraCare know. I understand that if I revoke this Authorization, My Providers and UltraCare will stop using and sharing My Information under this Authorization, and additional information will not be collected. My revocation will not affect uses and disclosures of My Information prior to my revocation. I understand that unless my consent is withdrawn, my consent is valid for the longer of either ten (10) years from the date signed below or as long as I receive services from the Program and for a reasonable time thereafter. I understand that I may receive a copy of this Authorization.

Print Patient or Authorized Patient Representative Name	X Signature of Patient or Authorized Patient Representative	Relationship to Patient	Date

3. AUTHORIZATION FOR ULTRACARE AND COMMUNICATIONS

By signing below, I confirm I would like to enrol in the UltraCare program and authorize UltraCare to provide me with Patient Support. I understand that UltraCare is an optional program. I agree that UltraCare may use My Information and share it with My Providers or My Plan in connection with providing the Patient Support, administering the UltraCare program, or as otherwise required by UltraCare to meet its legal obligations. For example, UltraCare may communicate with me (such as by mail, phone, email, and/or text message) or my caregiver, use My Information to tailor the UltraCare-related communications to my needs, and share information with My Providers about dispensing my EVKEEZA medicine to me. I understand that UltraCare may de-identify My Information, combine it with information about other patients, and use the resulting information for UltraCare reporting purposes.

Print Patient or Authorized Patient Representative Name	X Signature of Patient or Authorized Patient Representative	Relationship to Patient	Date

Patient Enrolment Form

4. OPT IN TO RECEIVE MARKETING COMMUNICATIONS (NOT REQUIRED FOR ULTRACARE ENROLMENT)

By checking this box, I authorize UltraCare, and companies working with UltraCare, to contact me by mail, email, fax, and/or telephone regarding marketing and promotional communications, customer surveys, or for market research surveys. **I understand that I am not required to provide this consent to receive marketing communications to receive EVKEEZA or UltraCare services.**

Print Patient or Authorized Patient Representative Name	X Signature of Patient or Authorized Patient Representative	Relationship to Patient	Date

IMPORTANT: If healthcare provider is unable to obtain written consent from patient, please document when patient verbal consent was obtained. This will allow the program to continue with processing this enrolment. Written consent will be obtained by the program. Verbal consent should be obtained by a healthcare provider.

☐ Patient consented verbally: Date (DD/MM/YYYY) _____

Patient consent obtained by: Name (First, Last) _____ Title: ☐ MD ☐ RN ☐ Other (specify) _____

Signature _____

By providing my email address, I agree to receive, electronically, communications from Innomar acting on behalf of Ultragenyx Pharmaceutical, Inc. containing information and updates relating to enrolment in the UltraCare Program.

I understand that I may withdraw any of my consents to such communications at any time by providing notice to Innomar Strategies, Inc., c/o UltraCare® Program, 2600 Alfred Nobel Blvd, Ville Saint-Laurent, QC H4S 0A9, or via email at Ultracare@innomar-strategies.com

You can report any suspected side effects associated with the use of health products to Health Canada at 1-866-234-2345 or http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/index-eng.php. You may also report side effects to Ultragenyx at 1-833-388-5872 (U-LTRA).

For Healthcare Providers

(Sections 5-9 to be read and completed by Healthcare Provider)

Patient Name (First, Last) _____

DOB (DD/MM/YYYY) _____

5. PRESCRIBER INFORMATION

First name _____ Street address _____

Last name _____ City _____

Office email _____ Province _____ Postal code _____

Office contact name/title _____ Office phone (_____) _____

Office contact phone (_____) _____ Fax (_____) _____

Licence # _____ Prescriber email _____

6. CONFIRMED DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH) BY:

☐ Clinically diagnosed

☐ Genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the *LDLR*, *APOB*, *PCSK9*, or *LDLRAP1* genes

☐ Confirmed diagnosis of OTHER _____

Patient Enrolment Form

7. PATIENT HISTORY

Patient Status and History

Current LDL-C value (pre-apheresis if applicable)

_____ mmol/L Date (DD/MM/YYYY) _____ /_____ /_____

Untreated LDL-C value (prior to treatment initiation)

_____ mmol/L Date (DD/MM/YYYY) _____ /_____ /_____

Total cholesterol value (pre-apheresis if applicable)

_____ mmol/L Date (DD/MM/YYYY) _____ /_____ /_____

Untreated total cholesterol value (prior to treatment initiation)

_____ mmol/L Date (DD/MM/YYYY) _____ /_____ /_____

Triglycerides value (pre-apheresis if applicable)

_____ mmol/L Date (DD/MM/YYYY) _____ /_____ /_____

Untreated triglycerides value (prior to treatment initiation)

_____ mmol/L Date (DD/MM/YYYY) _____ /_____ /_____

☐ Cutaneous or tendinous xanthoma Age of xanthoma onset _____

Family History

☐ Evidence of HeFH in both parents

Lipid-Lowering Treatments

	Treatment name	Dose	Current	Previous	Duration of treatment
☐ Statin	_____	_____	☐	☐	_____
☐ Ezetrol® (ezetimibe)		_____	☐	☐	_____
☐ PCSK9i	_____	_____	☐	☐	_____
☐ Juxtapid® (lomitapide)		_____	☐	☐	_____
☐ Other	_____	_____	☐	☐	_____

☐ Lipoprotein apheresis or ☐ Plasmapheresis ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

8. INFUSION SETTING AND ADMINISTRATION

Preferred Treatment Setting

☐ Out-patient clinic* ☐ Apheresis unit* * Provide contact name and phone number.

Contact name _____ Phone number _____

☐ Innomar clinic ☐ At home

9. EVKEEZA (EVINACUMAB FOR INJECTION) FOR INFUSION USE – PRESCRIPTION INFORMATION

The recommended dose for EVKEEZA is 15 mg/kg administered by intravenous (IV) infusions over 60 minutes every 4 weeks.
The rate of infusion may be slowed, interrupted, or discontinued if the patient develops any signs of adverse reactions, including infusion-associated symptoms.
EVKEEZA can be administered without regard to lipoprotein apheresis.

REQUIRED Patient's full name _____

Patient weight in kg _____

Date (DD/MM/YYYY) _____

Infusion fluid type **(please select one):**

☐ 0.9% sodium chloride injection

or

☐ 5% dextrose injection

Dose: 15 mg/kg IV every 4 weeks according to the weight of the day

Refills _____ Days' supply: 4 weeks

Special instructions/Indication: Administer by intravenous infusion over 60 minutes

If patient has already started treatment, EVKEEZA supply needed for scheduled treatment on (DD/MM/YYYY) _____ /_____ /_____

Supply format: EVKEEZA (evinacumab for injection) is supplied by 150 mg/mL concentrate for solution for infusion **(DIN: 02541769)**.
Please see full Product Monograph at https://www.ultragenyx.com/wp-content/uploads/2024/04/EvkeezaCA_Product_Monograph.pdf for complete dosage and administration information. I authorize PSP to be my designated agent to forward this prescription by fax, or other mode of delivery, to the pharmacy chosen by the above named. This prescription represents the original prescription drug order. The patient's chosen pharmacy is the only intended recipient and there are no others.

Prescriber Signature _____ **Date** _____

Special instructions _____

Special precautions (e.g., allergies) _____

The prescriber assumes responsibility for monitoring lab values. The prescriber assumes responsibility for notifying UltraCare of any dosage changes or suspension of therapy.