HOW TO COMPLETE THE STARTER Rx FORM

Completing and faxing back a signed Starter Rx form connects your patients to a range of personalized services to meet their needs. Incomplete information may result in delays in getting patients started on therapy. Here is a guide to ensure the form is complete:

Page 1 should be completed by the HEALTHCARE PROFESSIONAL (HCP)

STARTER Rx FORM
VELTASSA Konnect℠

1. **COMPLETE EACH SECTION ON BOTH PAGES**
2. **SIGN:** Prescriber signs page 1
   Patient or patient's legal representative signs page 2
3. **FAX both pages to 1-888-623-7092**
   - Include copies of both sides of insurance card

QUESTIONS?
Call 1-844-870-7597, Monday through Friday from 9 am to 8 pm Eastern Time.

1. PATIENT INFORMATION (Please provide physical address; no PO boxes)

Patient Name (Last, First) Smith, John
Address 123 Main Street
City Anytown State CA Zip 00012
Date of Birth 05 / 05 / 5555 ☑ Male ☐ Female
Primary Phone (555) 345 - 6789 Best Time to Call 5-9 pm
Secondary Phone (555) 345 - 1234

Patient Preferred Language English
Patient's Legal Representative Name (If applicable) Sally Smith
Patient's Legal Representative Phone (555) 345 - 5678
Relationship to Patient Daughter

☐ If the patient or patient's legal representative is unavailable to sign this form, please have VELTASSA Konnect send the form to the patient immediately for completion. (Patients may also visit www.VELTASSAeconsent.com to provide their authorization electronically.)

2. PRESCRIBER INFORMATION

Prescriber Name Daniel Harrison, MD
Address 123 Elm Street
City Anytown State CA Zip 00012
Phone (555) 901 - 2345 Fax (555) 901 - 2346
State License # 123456789

Treating Facility Name Harrison and Co.
Specialty Nephrology
Office Contact Name Jane Clark
Prescriber NPI 1234 Group NPI 123456

3. INSURANCE INFORMATION (Please attach copy of medical and prescription drug insurance cards [both sides]) ☐ Patient is uninsured

PRIMARY MEDICAL INSURANCE
Primary Insurance Name ABC Health Plan
PI Policy # 1234567890
PI Group # 1234
PI Phone (555) 921 - 4523
Policyholder Name John Smith

PRESCRIPTION DRUG COVERAGE
Rx Insurance Name ABC Rx
Rx Member ID # 12345 Rx Phone (555) 234 - 5678
PCN 123 BIN 54321
Rx Group # 098765432I
Rx Policyholder Name John Smith

4. VELTASSA® (patiromer) FOR ORAL SUSPENSION PRESCRIPTION

VELTASSA START PROGRAM*: Upon prescriber's medical assessment of patient need, Relypsa will provide eligible new patients with a free trial offer of up to 30 days of VELTASSA.

☑ **Yes, provide patient with a free supply of VELTASSA. Dose 8.4 g once daily and dispense up to a 30-day supply as directed below.**

☑ Ship to patient's address ☐ Ship to doctor's office ☐ Other facility (Please indicate below)
Contact Name _____ Phone (____) _____ - _____
Address _____ City _____ State _____ Zip _____

Dissolve contents of one (1) packet into 1/3 cup of water and drink full amount once daily. Take as directed.

☑ 8.4 g once per day ☐ 16.8 g once per day ☐ 25.2 g once per day ☐ Other _____
Dispense: ☐ 30-day supply ☐ Other _____ ☑ 90-day supply
Refill 4 times

PATIENT DIAGNOSIS/ICD-10 CODE(S)
☑ Hyperkalemia E87.5 ☐ Other _____

Medical records can be attached for the following items:
Serum Potassium Level 5.1 mEq/L
Allergies None
Current Medications See attached list

PRESCRIBER DECLARATION
I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I 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 Relypsa, and parties working with Relypsa, to perform a preliminary assessment of insurance verification and determine patient eligibility for the Relypsa product program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program.

Prescriber Signature Daniel Harrison, MD **Date** 9/1/16
(No stamps) (Dispense as written)
Prescriber Signature _____ **Date** _____
(No stamps) (Substitution permitted)

*VELTASSA Start Program not contingent on purchase. No guarantee VELTASSA will be approved by patient's health plan.

Page 1 of 2 Please complete the form, sign, and fax all pages to 1-888-623-7092 PP-US-VEL-00283.

When possible, have the patient or patient's legal representative review and sign the Starter Rx form. If they are unable to sign the Starter Rx form, VELTASSA Konnect will contact them directly. They may also visit www.VELTASSAeconsent.com to provide their authorization electronically.

A Fill out all patient information fields completely and accurately, including patient or patient's legal representative phone number. Note that PO boxes are not valid addresses.

B Remember to check this box if the patient or patient's legal representative is unavailable to sign this form.

C Enroll a new patient with hyperkalemia, based on your judgment of medical necessity, into the VELTASSA Start Program by checking "yes." This will provide the patient with a free trial supply of up to 30 days of VELTASSA® (patiromer) For Oral Suspension.

D **For delivery direct to the patient:** We must speak with the patient prior to shipping VELTASSA. Please remind patients to contact us immediately if they miss our call so that the starting supply of VELTASSA can be shipped.

If your patient does not want to wait for a call, they can call VELTASSA Konnect directly at 1-844-870-7597 and dial 0 to schedule their starting supply shipment. Just write "Phone Enrollment" at the top of the Starter Rx form.

For delivery to the HCP's office: The shipment of VELTASSA is not contingent upon reaching the patient if they sign the Starter Rx form.

For delivery to other facilities: Please fill out the contact name, phone number, and address in the space provided.

Delivery to the HCP's office and other facilities is only available for VELTASSA Start shipments.

E This information is the patient's prescription. Ensure the correct dosage and dispensing boxes are checked, including any refills required.

F Check the appropriate diagnosis code box and write in lab values. Medications and allergy information can be printed and faxed along with the Starter Rx form.

G **Remember to sign and date the prescriber declaration.**

Page 2 should be completed by the PATIENT or PATIENT'S LEGAL REPRESENTATIVE

TO BE FILLED OUT BY THE PATIENT FOR ENROLLMENT IN VELTASSA Kˆonnect

PRIVACY NOTICE & PATIENT AUTHORIZATION

By signing this Authorization, I authorize Relypsa, and companies and parties working with Relypsa (collectively "Relypsa"), to use and/or disclose my 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 Relypsa for the purposes stated below. I understand this Authorization is voluntary, but Relypsa cannot provide me services and information without it.

VELTASSA Kˆonnect is a program sponsored by Relypsa that provides patient support and helps eligible patients access, afford, be informed about, and comply with their treatment as prescribed.* Once my health information has been disclosed, I understand that privacy laws may no longer protect the information. However, Relypsa 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, such as my pharmacy provider, may receive remuneration from Relypsa in connection with the activities described in this Authorization.

I authorize the use and/or disclosure of my health information for the following purposes: (1) for my enrollment, determination of my eligibility, and my participation in VELTASSA Kˆonnect and for the administration of the program; (2) to help communicate with me, my health plan, my provider, or my pharmacy about my medical care and insurance status; (3) to verify my insurance information; (4) to provide education and ongoing support for my treatment as prescribed; (5) to refer me to alternative third-party patient programs; (6) to provide me with information about Relypsa products, health topics, and programs and ask for my opinions; (7) for business evaluation purposes; and (8) to comply with law. This may include the occasional receipt and exchange of information with Relypsa for marketing purposes and I have the option to opt-out below. I understand and agree that Relypsa may contact me by mail, email, telephone, and/or text. Relypsa will generally leave voice messages with basic information. I authorize Relypsa to leave me voice messages with more detailed information about the reason for the call, which may contain more health information.

I understand that I may refuse to sign this Authorization and choose not to receive information or services from Relypsa. I understand that my treatment (including with a Relypsa 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 Relypsa at: Relypsa, PO Box 43848, Louisville, KY, 40253. Canceling this Authorization will end my consent after the date Relypsa receives my letter but will not affect information previously disclosed pursuant to this Authorization.

H

John Smith	John Smith	9/1/16
Patient or Patient's Legal Representative Name (Print)	Patient or Patient's Legal Representative Signature	Date

Describe representative's relationship to patient _____

This Authorization shall be in effect for five (5) years from the date of my signature, unless a shorter period is required by law or it is canceled in writing. I may receive a copy of this Authorization upon request. I certify that all the information I provide to Relypsa is complete and accurate to the best of my knowledge.

I

Other Communications: My signature above provides consent to receive additional disease and product information and to be contacted for my opinions as part of Relypsa's marketing communications, which are separate from VELTASSA Kˆonnect. I may opt-out of this type of use and/or disclosure of my health information by checking the box below or by contacting Relypsa.

☐ Please do not provide me with additional information or ask for my opinions as part of Relypsa's marketing communications.

*Any free product provided under the program cannot be submitted for reimbursement and shall be used as prescribed.

VELTASSA Kˆonnect PATIENT ASSISTANCE PROGRAM (PAP) FOR UNINSURED AND UNDERINSURED APPLICANTS ONLY

J

Annual pre-tax household income: $60,000 **Number of family members living in household:** 4

Uninsured and underinsured PAP applicants are required to submit verification for all sources of household income at time of application, including a copy of one (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 only be used to determine eligibility for the PAP. If you do not have one of the above-mentioned sources, please call 1-844-870-7597 for more information. Please promptly notify Relypsa of any change in your insurance or financial status under the PAP.

 Please complete the form, sign, and fax all pages to 1-888-623-7092 PP-US-VEL-00283.

H The patient or patient's legal representative should read and sign the privacy notice and patient authorization form. This signature is required to gain access to patient services. A missing signature will delay this process. Note that the printed name and signature on page 2 must match to process the form.

I Check this box if your patient does not wish to receive additional communications from Relypsa.

J Patients who are uninsured or underinsured and in financial need may apply for free product by completing this section and submitting income verification.

ENROLL YOUR PATIENTS TODAY.

relypsa
A Vifor Pharma Group Company