HOW TO ENROLL IN

VELTASSA Konnect℠

Please complete this form in its entirety with your patient.

1. Please be sure to complete all patient information, insurance information, prescribed dosing (including authorization for the VELTASSA Start Program, a free trial for new patients), and prescriber information.
2. Prescribing physician must sign and date prescriber declaration.
3. Patient or patient representative must sign Privacy Notice and Patient Authorization.
4. Patients applying for financial assistance must complete the Patient Assistance Program section and provide all required documentation as described.
5. Please remember to include a copy, both front and back, of the patient's insurance card.
6. Please be sure form is completed and FAX back all pages to 1-888-623-7092.

The form cannot be processed without an original signature and date. Stamped signatures cannot be accepted.

QUESTIONS?

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

The Starter Rx Form is also available online at VELTASSAhcp.com.

STARTER RX FORM

VELTASSA Konnect℠

1. **COMPLETE**
2. **SIGN**
   – Prescriber signs page 1
   – Patient 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.

PATIENT INFORMATION

(Please provide mailing address; no PO boxes)

Patient Name (Last, First) _____

Mailing Address _____

City _____ State _____ Zip _____

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

Cell Phone (____) _____ - _____ Alt. Phone (____) _____ - _____

Patient Email _____

Patient Representative (if applicable) _____

Patient Representative Phone (____) _____ - _____

Relationship to Patient _____

INSURANCE INFORMATION

Please attach copy of medical and prescription drug insurance cards (both sides)

Copy of Insurance Card Attached? ☐ Yes ☐ Patient is Uninsured

PRIMARY MEDICAL INSURANCE

Primary Insurance (PI) Name _____

PI Policy # _____

PI Group # _____

PI Phone (____) _____ - _____

Policy Holder Name _____

Rx PRESCRIPTION DRUG INSURANCE

Rx Insurance Name _____

Rx Member ID # _____ Rx Phone (____) _____ - _____

PCN _____ BIN _____

Rx Group # _____

Rx Policyholder Name _____

VELTASSA (patiromer) PRESCRIPTION

VELTASSA Start Program*: Upon prescriber's medical assessment of patient need, Relypsa will provide eligible new patients with a free 15-day trial offer. Second free 15-day supply available while they await their final insurance coverage determination.

☐ Yes, provide patient with a free supply of VELTASSA. Starting dose 8.4 g daily and dispense up to two 15-day supplies as directed below

☐ Ship to patient's address ☐ Ship to doctor's office

Dissolve contents of one (1) packet in three (3) ounces of water and drink full amount once daily. Take as directed, per enclosed Medication Guide.

☐ 8.4 g once per day ☐ 16.8 g once per day ☐ 25.2 g once per day ☐ Other _____

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

Refill _____ times

NY prescribers – *Please submit prescription per your NY State requirements.* TN prescribers – *Quantity must be written in both numerals and words.*

Patient Diagnosis/ICD-10 Code(s)

☐ Hyperkalemia E87.5 ☐ Other _____

Serum Potassium Level _____

Current Medications _____

Allergies _____

PRESCRIBER INFORMATION

Prescriber Name _____

Address _____

City _____ State _____ Zip _____

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

State License # _____ DEA # _____

Practice Name _____

Specialty _____

Office Contact Name _____

Office Contact Email _____

Prescriber NPI _____ Group NPI _____

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 _____ _____
(No Stamps) (Dispense as Written) Date

Prescriber Signature _____ _____
(No Stamps) (Substitution Permitted) Date

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

☐ If the patient or representative is unavailable to sign this form, please have VELTASSA K+onnect send the form to the patient immediately for completion

TO BE FILLED OUT BY THE PATIENT FOR ENROLLMENT IN VELTASSA K+onnect

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 K+onnect 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 K+onnect 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, e-mail, telephone, and/or text.

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.

Patient or Representative Name (Print)	Patient or Representative Signature (Describe representative's relationship to patient)	Date

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.

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 K+onnect. 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.

OPTIONAL VELTASSA K+ONNECT PATIENT ASSISTANCE PROGRAM (PAP) FOR UNINSURED AND UNDERINSURED APPLICANTS ONLY

Annual pre-tax household income: _____ **Number of family members living in household:** _____

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 PAP.

relypsa

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