TRAVERE TotalCare®

FILSPARI® (sparsentan) Patient Start Form

This form acts as a prescription for FILSPARI and also enrolls your patient into Travere TotalCare®

Complete all fields and fax form to 1-888-381-0625 *INDICATES REQUIRED FIELD

PATIENT INFORMATION

*Name: (First)_____ (MI)___ (Last)_____

*DoB:____ /___ /_____ Sex Assigned at Birth: ☐ Male ☐ Female

*Shipping Address:_____ Apt #:_____

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

*Primary Phone #: (_____)_____-_____

*Email:_____

Preferred language: ☐ English ☐ Spanish ☐ Other:_____

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

PATIENT INSURANCE INFORMATION

Does the patient have insurance? ☐ Yes ☐ No

IF YES, FILL OUT INFORMATION **OR** ATTACH COPIES OF **FRONT AND BACK** OF PRESCRIPTION INSURANCE CARDS

*Primary Pharmacy Carrier:_____

*Policy Phone #: (_____)_____-_____

*Name of Insured (Cardholder):_____

*Rx Member ID:_____

Rx Group ID:_____ Rx BIN:_____

Rx PCN:_____

PATIENT CERTIFICATION AND AUTHORIZATION

By signing below, I confirm that I have read and understand the Authorization to Share Health Information and Patient Support on page 2 and agree to the terms.

*Signature of Patient or Legal Representative:_____

Printed Name of Patient or Legal Representative:_____

Relationship to Patient (if applicable):_____ *Date:____ /___ /_____

☐ I would like to opt-in for other programs and resources from Travere and its service providers and agree to the Opt-in for Other Resources terms on page 2 (optional).

PRESCRIBER INFORMATION

*Full Prescriber Name:_____

*Address:_____

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

*Prescriber NPI:_____

*Office Fax: (_____)_____-_____

*Practice Name:_____

Practice Phone #: (_____)_____-_____

Office Contact Name:_____

Office Contact Phone #: (_____)_____-_____

*Office Prior Authorization Email:_____

CLINICAL INFORMATION

*Diagnosis:

☐ N02.B Primary Immunoglobulin A Nephropathy (IgAN)

☐ Other Diagnosis:_____

*Has the patient had a kidney biopsy? ☐ Yes ☐ No

Will the patient discontinue an ACEi/ARB prior to starting FILSPARI as required? (if applicable) ☐ Yes ☐ No

PRESCRIPTION INFORMATION

The Patient Start Form acts as a prescription for FILSPARI

FILSPARI PRESCRIPTION (select one)

☐ **Recommended**

Days 1-14: One 200 mg PO QD x 14 days #14 tablets Refills: 0
Days 15-30: Two 200 mg PO QD x 16 days #32 tablets Refills: 0
Days 31+: One 400 mg PO QD x 30 days #30 tablets Refills:___

☐ 200 mg PO QD x 30 days #30 tablets Refills:_____

☐ Other:_____

QUICKSTART FILSPARI PRESCRIPTION (select one)

By selecting QuickStart, I believe my patient is at risk of rapid disease progression and a delay in therapy could lead to a negative outcome. I authorize TC Script to provide up to 60 days' supply of FILSPARI dispensed directly to the above-named patient at no cost, while I coordinate with the patient's insurance.

☐ **Recommended**

Days 1-14: One 200 mg PO QD x 14 days #14 tablets Refills: 0
Days 15-30: Two 200 mg PO QD x 16 days #32 tablets Refills: 0
Days 31+: One 400 mg PO QD x 30 days #30 tablets Refills: 0

☐ **Other**

Days 1-30: One 200 mg PO QD x 30 days #30 tablets Refills: 1
Up to 60 days total

PRESCRIBER AUTHORIZATION (Handwritten signatures only; e-signatures and stamps not acceptable)

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Prescriber Signature (dispense as written)_____ **Date of Signature** (mm/dd/yyyy):____ /___ /_____

Prescriber Signature (substitution permitted)_____ **Date of Signature** (mm/dd/yyyy):____ /___ /_____

By signing above, I verify that my patient has provided a signed HIPAA Authorization that allows me to share protected health information with Travere TotalCare® for purposes of the Patient Support Program. I further verify the information and prescription provided in this FILSPARI® Start Form and Prescription is complete and accurate to the best of my knowledge. I certify that this medication is medically necessary for the patient. I understand that Travere Therapeutics, Inc. ("Travere") reserves the right at any time and for any reason, without notice, to modify this form or to modify or discontinue any services or assistance provided through Travere TotalCare®. I authorize Travere and its designated agents to use and discontinue any services or assistance provided through Travere TotalCare®. I authorize Travere and its designated agents to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through Travere TotalCare® (as applicable) to assess my patient's eligibility for copay assistance and for quality and data assurance purposes.

By signing this form, I further certify that the information provided in this form is accurate to the best of my knowledge and that the patient meets the eligibility requirements of any Travere TotalCare® selected above, including without limitation, the requirement that the patient be prescribed FILSPARI for an FDA-approved indication. I acknowledge and agree that I may not bill for medication dispensed under the QuickStart Program or Patient Assistance Program to any private or government payer or other third party and that I will adhere to the terms and conditions of the programs.

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For more information about FILSPARI, please visit **FILSPARIhcp.com** and for additional information regarding REMS, visit **FILSPARI-REMS.com**.

Authorization to Share Health Information and Patient Support

The Travere TotalCare® Program ("Program") is a support program for patients by Travere Therapeutics, Inc. ("Travere"). Before signing, the patient and/or patient's authorized representative should review and understand the terms of this Authorization to Share Health Information and Patient Support ("Authorization"). If an authorized representative signs for the patient, please indicate the relationship to the patient.

I understand that the collection, use, and disclosure of the patient's health information are protected under law. Information contained in this FILSPARI® Start Form and Prescription, such as the patient's name, address, insurance, prescription, and medical information, may be "protected health information" ("PHI"). By signing this Authorization, the patient agrees to the collection, use, and disclosure of the patient's PHI as described below and authorizes their treating physician, healthcare provider, health insurer, or pharmacist ("Insurer and Treating Providers") to share such information with Travere and the company or companies that help Travere administer the Program's Support Services ("Services").

I understand that once PHI about the patient is released based on this Authorization, federal privacy laws may not prevent Travere and company or companies who administer the Services from further disclosing the patient's information. However, I understand that such entities have agreed to use or disclose PHI they receive only for the purposes described in this Authorization or as required by law.

By signing this form, I authorize Travere and the company or companies that help administer the Services, to do the following:

- Request and receive information from the patient's Insurer and Treating Providers necessary to investigate and resolve the patient's insurance coverage, coding, or reimbursement inquiry or to provide the reimbursement support service that I have requested. Information may include the patient's medical diagnosis, condition, and treatment (including prescription information), the patient's health insurance, name, address, and telephone number;
- Collect, use, and disclose any patient information, including patient name, contact information, information related to disease, diagnosis, and treatment, medical insurance information, some of which may be considered PHI or consumer health data as defined by applicable law, for the purpose of investigating and resolving the patient's insurance coverage, coding, or reimbursement inquiry or to administer the Services, including entering and maintaining the patient's information in a database;
- Disclose patient information as described above with Travere's service providers, contractors, analytics service providers, and business partners, including our business partners who support our research, surveys, focus groups or interviews related to the patient's diagnosis and the effectiveness of the Program;
- Disclose patient information as described above to the patient's Insurer and Treating Providers as necessary to resolve the patient's insurance coverage, coding, or reimbursement inquiry. The patient authorizes their Insurer and Treating Providers to release PHI about the patient's prescribed medications and medical condition requested by Travere and the company or companies that help Travere administer the Services;
- Contact the patient's plan(s) about their insurance benefit, coverage status, and product administration (eg, prescription, dosing, refills);
- Provide financial assistance resources, including copay assistance or free drug programs if I meet program eligibility; and
- Contact the patient's Insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs (eg, the Travere TotalCare® Program) on the patient's behalf to determine if the patient may be eligible for health insurance coverage or other funds, and disclose to them PHI about the patient's prescribed medications and medical condition that has been provided by the patient or patient's authorized representative or patient's Insurer and Treating Providers.

I understand that I may decline to sign this Authorization, and that doing so will not affect the patient's ability to receive FILSPARI® (sparsentan) or obtain insurance or insurance coverage. This Authorization will expire in 10 years or a shorter period if required by state law. I understand that I may revoke or cancel it at any time by calling 833-345-7727 or by writing to Travere TotalCare®, 2250 Perimeter Park Dr, Suite 300, Morrisville, NC 27560. I understand that I am entitled to receive a copy of this Authorization, upon request.

I further understand that revoking this Authorization will prohibit PHI disclosures after the date written revocation is received by the Program, except to the extent that action has been taken already on this Authorization. After I revoke this Authorization, the patient's PHI may be disclosed among Travere and the company or companies that help Travere administer the Services in order to maintain records of the patient's participation, but it will not be otherwise disclosed or used. Further information on Travere's privacy practices can be found at https://travere.com/privacy/.

I understand that the pharmacy who may administer some of the Services may receive payment from Travere as the manufacturer in exchange for securely sharing the patient's PHI with companies who administer the Services.

Opt-In for Other Resources

By checking the box on page one, I additionally authorize Travere and its service providers to contact me by mail, email, telephone, or alternative communication to discuss and receive marketing communications, invitations to participate in research, educational materials, treatment support services and patient engagement initiatives designed for people taking FILSPARI®, including nutritional support and counseling.

Power of Attorney documentation is required if an adult other than the patient signs. You may fax the documents to 888-381-0625 or call 833-345-7727 for further assistance. NOTE: Enrollment cannot be processed without a valid signature.

Please complete all fields and fax form to 1-888-381-0625

Call us at 1-833-345-7727. Monday-Friday, 8 AM-8 PM ET.
Mail us at: Travere TotalCare®, 2250 Perimeter Park Dr, Suite 300, Morrisville, NC 27560