HOW TO ENROLL IN

VELTASSA Konnect℠

Please complete this form in its entirety with your patient. It will be used as a prescription and for enrollment in VELTASSA Konnect.

1. Please be sure to complete all patient information, prescriber information, insurance information, and prescribed dosing (including authorization for the VELTASSA Start Program, a free trial for new patients).
2. Fill out the prescription section completely and accurately to avoid delays.
3. The prescribing physician must sign and date the prescriber declaration.
4. Patients or their legal representative must sign the Privacy Notice and Patient Authorization. They may also visit **www.VELTASSAeconsent.com** to provide their authorization electronically. Note that the printed name and signature on page 2 must match to process the form.
5. Patients applying for financial assistance must complete the Patient Assistance Program section on page 2 and provide all required documentation as described.
6. Please remember to include a legible copy, both front and back, of the patient's insurance card.
7. Please be sure the form is fully completed and fax back all pages to 1-888-623-7092.

The form cannot be processed without an original prescriber 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 www.VELTASSAhcp.com

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) _____
Address _____
City _____ State _____ Zip _____
Date of Birth ____/____/____ ☐ Male ☐ Female
Primary Phone (____) _____ - _____ Best Time to Call _____
Secondary Phone (____) _____ - _____

Patient Preferred Language _____
Patient's Legal Representative Name _____
(If applicable)
Patient's Legal Representative Phone (____) _____ - _____
Relationship to Patient _____

☐ **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 _____
Address _____
City _____ State _____ Zip _____
Phone (____) _____ - _____ Fax (____) _____ - _____
State License # _____

Treating Facility Name _____
Specialty _____
Office Contact Name _____
Prescriber NPI _____ Group NPI _____

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

☐ Patient is uninsured

PRIMARY MEDICAL INSURANCE

Primary Insurance Name _____
PI Policy # _____
PI Group # _____
PI Phone (____) _____ - _____
Policyholder Name _____

PRESCRIPTION DRUG COVERAGE

Rx Insurance Name _____
Rx Member ID # _____ Rx Phone (____) _____ - _____
PCN _____ BIN _____
Rx Group # _____
Rx Policyholder Name _____

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 _____ **times**

PATIENT DIAGNOSIS/ICD-10 CODE(S)

☐ Hyperkalemia E87.5 ☐ Other _____

Medical records can be attached for the following items:

Serum Potassium Level _____
Allergies _____
Current Medications _____

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 _____ **Date** _____
(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.

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, 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.

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.

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.

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 the PAP.

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