A·S·A·P
ASCENDIS SIGNATURE ACCESS PROGRAM®

Fax: 1-855-813-2039
Phone: 1-844-44ASCENDIS (1-844-442-7236)
www.Yuviwelhcp.com

yuviwel® navepegritide
for injection 1.3 · 2.8 · 5.5 mg

*Required field.

PATIENT ENROLLMENT FORM

Please select your patient's treatment experience*:
❑ New to YUVIWEL® (navepegritide) ❑ Switching from previous therapy: _____ ❑ Continuing on YUVIWEL

❑ YUVIWEL FastStart ❑ Injection training support ❑ Ascendis Patient Assistance Program ❑ A·S·A·P Bridge Support

1-PATIENT INFORMATION

Patient name*: _____
Date of birth*: _ _ / _ _ / _ _ _ _ Sex*: ❑ M ❑ F
Address*: _____
City*: _____ State*: ___ ZIP*: _____
Primary language: _____

Parent/Guardian #1:
Name*: _____
Relationship to patient*: _____
Phone*: (_ _ _) _ _ _ - _ _ _ _
Email: _____

Parent/Guardian #2:
Name: _____
Relationship to patient: _____
Phone: (_ _ _) _ _ _ - _ _ _ _
Email: _____

2-INSURANCE

❑ Copies of front and back of primary medical insurance and pharmacy insurance (if applicable) cards are attached
❑ Patient has pharmacy insurance ❑ Patient is not insured

Primary medical insurance*: _____
Pharmacy/Rx insurance: _____
Member ID #*: _____ Group ID #: _____
Member name: _____
Phone: (_ _ _) _ _ _ - _ _ _ _

Prior authorization (PA) submitted: ❑ Yes ❑ No
PA approval: ❑ Yes ❑ No
Date of PA approval: _ _ / _ _ / _ _ _ _
Reference number: _____

3-DIAGNOSIS

❑ **Please check box to confirm ICD-10 diagnosis: Q77.4 Achondroplasia***
ICD-10 CM Q77.4 is used for achondroplasia; YUVIWEL is only indicated for increasing linear growth in pediatric patients with achondroplasia and open growth plates (epiphyses).

4-MEDICAL ASSESSMENT

Please provide the following details:
Current weight*: _____ **kg**
Date of measure*: _ _ / _ _ / _ _ _ _
Height: _____ cm
Date of measure: _ _ / _ _ / _ _ _ _

Known drug allergies: ❑ Yes ❑ No
If yes, list allergies*: _____
Concurrent medications*: _____

Confirmed FGFR3 mutation
Date of test: _ _ / _ _ / _ _ _ _
Open epiphyses*: ❑ Yes ❑ No
X-ray date: _ _ / _ _ / _ _ _ _

5-PRESCRIBER INFORMATION

Prescriber name*: _____
Practice*: _____
DEA #: _____
Prescriber NPI #*: _____

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

Office contact*: _____
Office contact phone*: (_ _ _) _ _ _ - _ _ _ _
Office contact fax*: (_ _ _) _ _ _ - _ _ _ _
Office contact email*: _____

6-PRESCRIPTION/ DOSAGE

YUVIWEL weekly subcutaneous dose and injection volume (please select the weekly dose/injection volume based on the patient's body weight)*:

1.3 mg vial (NDC 73362-201-01)
❑ **8.0 to 9.9 kg**; 0.88 mg (0.40 mL) SC weekly
❑ **10.0 to 13.4 kg**; 1.2 mg (0.55 mL) SC weekly

2.8 mg vial (NDC 73362-202-01)
❑ **13.5 to 17.5 kg**; 1.6 mg (0.35 mL) SC weekly
❑ **17.6 to 23.0 kg**; 2.1 mg (0.45 mL) SC weekly
❑ **23.1 to 30.5 kg**; 2.8 mg (0.60 mL) SC weekly

5.5 mg vial (NDC 73362-203-01)
❑ **30.6 to 41.2 kg**; 3.6 mg (0.65 mL) SC weekly
❑ **41.3 to 55.9 kg**; 5.0 mg (0.90 mL) SC weekly
❑ **56.0 to 73.5 kg**; 6.6 mg (2 x 0.60 mL) SC weekly
❑ **73.6 to 90.0 kg**; 8.8 mg (2 x 0.80 mL) SC weekly

Month(s) supply: _____ **Refills:** _____

7-PRESCRIBER AUTHORIZATION†

I certify that the information provided above is, to the best of my knowledge current, complete, and accurate and the therapy I have prescribed above is medically necessary for this patient and patient's records contain supporting documentation that substantiates the utilization and medical necessity of the therapy. I have discussed A·S·A·P with my patient and my patient would like to be screened for eligibility for A·S·A·P and provided, if applicable, any services under A·S·A·P. I will comply with my own state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language. I understand that noncompliance with state-specific requirements could result in outreach to the prescriber. I authorize the provision to patient of ancillary supplies, such as sharps containers and alcohol swabs, to administer the therapy. I acknowledge that the prescription may only be filled by a limited number of specialty pharmacies and prescriber authorizes Ascendis and those acting on its behalf to transmit the prescription electronically, by facsimile, or by mail to the appropriate dispensing specialty pharmacy.

❑ Dispense as written
Prescriber signature†: _____
Date: _ _ / _ _ / _ _ _ _

❑ Substitution allowed
Prescriber signature†: _____
Date: _ _ / _ _ / _ _ _ _

8-†TRAINING SUPPORT AUTHORIZATION

Injection Training Support Authorization A·S·A·P will provide my patient/patient's caregiver with training on the proper administration of YUVIWEL. I am requesting A·S·A·P to coordinate YUVIWEL injection training support for my patient/patient's caregiver. I will receive information on the injection training support that my patient/patient's caregiver has received via the fax number I provided above. This order is valid for 1 year.

❑ **I do not wish to have my patient/patient caregiver trained by A·S·A·P.** By checking this box and opting out of injection training support, I acknowledge that I will assume responsibility and arrangements for YUVIWEL injection training for this patient/patient caregiver.

YUVIWEL will be dispensed solely through AnovoRx.
FGFR3 = fibroblast growth factor receptor-3; SC = subcutaneous.
†This form cannot be processed without prescriber's signature.

ascendis pharma

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