



**Patient Enrollment Form for
ROCTAVIAN™ (valoctocogene roxaparvovec-rvox)**

Please sign, date, and fax completed form to 1.833.979.2207
To learn more about BioMarin RareConnections™ call **1.833.ROCTAVIAN** (1.833.762.8284),
hours **M–F, 8 AM–8 PM (ET)**



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All required fields are purple and bolded

PATIENT	First Name		Middle Initial	Last Name		Suffix	
	Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other				
	Address					Floor/Suite/ Unit	
	City					State	ZIP Code
	Primary Phone		Mobile Phone <input type="checkbox"/> (same as primary)		Email		
	Preferred Method of Contact <input type="checkbox"/> Primary Phone <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Email				Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other language (please specify)		
	Authorized Representative Name (if applicable)					Relationship to Patient	
	Phone			Email			

PRESCRIBER	First Name			Last Name			
	Specialty			NPI Number			
	State License Number		Medicaid Number		Tax ID		
	Name of Institution/Practice						
	Address					Floor/Suite/Unit	
	City					State	ZIP Code
	Phone		Fax		Email		
	Preferred Method of Contact <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email						
Primary Contact Name (if different from prescriber)							
Phone		Fax		Email			

INSURANCE	Provide copies of all medical and prescription cards — front and back					
	<input type="checkbox"/> Patient has no insurance					
	Primary Medical Insurance Name				Insurance Phone	
	Subscriber Name			Relationship to Patient		
	Member ID		Group		Plan Code	
	Prescription (PBM) Insurance Name				Insurance Phone	
	Subscriber Name					
Member ID		RxBIN		RxPCN		RxGROUP

Patient's Full Name	Date of birth (mm/dd/yyyy)
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DIAGNOSIS / CLINICAL	ICD Code: <input type="checkbox"/> D66.0 Hereditary factor VIII deficiency (please specify below) <ul style="list-style-type: none"> <input type="checkbox"/> Classic hemophilia <input type="checkbox"/> Deficiency factor VIII (with functional defect) <input type="checkbox"/> Hemophilia NOS <input type="checkbox"/> Hemophilia A <input type="checkbox"/> Other diagnosis (Please specify) _____
	Patient allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Yes (please list)
	Concurrent medications

INFUSION SITE	<input type="checkbox"/> Information provided in Prescriber section on first page		
	Infusion Site Name		
	Address		Floor/Suite/Unit
	City		State ZIP Code
	Infusion Site NPI		Infusion Site Contact (if available)
	Phone	Fax	Email

PRESCRIPTION	Current weight (kg)	Date weight measured (mm/dd/yyyy)
	ROCTAVIAN™ (valoctocogene roxaparvovec-rvox) is provided in 10 mL vials containing an extractable volume of no less than 8 mL (6 x 10 ¹³ vg). Dose volume is based on body weight. To calculate a patient's dose in milliliters (mL), multiply body weight in kg by 3. The multiplication factor 3 represents the per-kilogram dose (6 x 10 ¹³ vg/kg) divided by the amount of vector genomes per mL of the ROCTAVIAN solution (2 x 10 ¹³ vg/mL). To calculate number of vials to be thawed, divide patient's dose volume in mL by 8 and round up to the next whole number of vials.	
	_____ × 3 = _____ / 8 = _____ Patient's weight (kg) Dose (mL) number of vials required	
	Directions: Administer _____ ml as a single intravenous infusion per manufacturer product labeling	
Dose: _____ vg Dispense (number of vials): _____		Refills: None NDC #: 68135-0927-48

PRODUCT COORDINATION	<input type="checkbox"/> Ship-to-site for product (if different from infusion site) <input type="checkbox"/> (select if same as infusion site)		
	Ship-to-site Name		
	Address		Floor/Suite/Unit
	City		State ZIP Code
	Ship-to-site Contact Name		Phone Fax
	Email	Shipping Instructions	

PRESCRIBER DECLARATION	<p>Prescriber Declaration: By signing below, I, as the prescribing physician, certify that the information provided on this form was completed by me or at my direction. I understand and agree that, as the Prescriber, I will comply with my 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 me, as the Prescriber.</p> <p>I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed ROCTAVIAN based on my professional judgment of medical necessity. I have informed my patient of the resources available in the BioMarin RareConnections program and have confirmed my patient's (or their respective caregiver's) consent to enroll in the program. I have obtained all required patient permissions and have complied with all federal and state laws with respect to disclosures and release of the provided information to BioMarin Pharmaceutical Inc., BioMarin RareConnections, and its affiliates, agents, and contractors (collectively, "BioMarin", as well as to or between other service providers such as laboratories and pharmacies, and for the purposes described herein by any means allowed under applicable law.</p> <p>I understand that the information provided herein will be used for the purposes of BioMarin to investigate and verify patient's insurance and coverage benefits, to contact this patient to help obtain a signed patient consent form and/or to refer the patient to or contact the patient for purposes of enrollment in a patient education program, verify patient's insurance coverage benefits for ROCTAVIAN and any related services, to coordinate the dispensing and delivery of ROCTAVIAN (including transmitting the prescription to the appropriate pharmacies) utilizing the patient's benefit plan, assist in initiating or continuing therapy, provide prior authorization and appeals information, verify eligibility for a co-pay program, and identify additional financial resources, provide me and my patient with other education and support associated with ROCTAVIAN, and for BioMarin internal business purposes such as conducting quality control, data analysis, and gathering feedback to improve patient support and resources. By enrolling my commercially insured patient into the laboratory co-pay program, I acknowledge only those tests appropriate for determining eligibility and necessary follow-up for an FDA-approved use are eligible for co-pay support and that participation in the program is not contingent upon the recommendation, ordering, prescription, or purchase of any other product or service.</p>	
	Prescriber's Signature. Please make a selection	
	Prescriber's Signature/Dispense as Written (no stamps or initials) Date	Prescriber's Signature/Substitution Permitted (no stamps or initials) Date