

For providers and ordering pharmacies: To ensure that all product orders arrive in time for the patient's infusion, we kindly remind you that all product orders to the distributor must be made at a minimum of 10 calendar days prior to the scheduled infusion. To ensure our patients receive the most accurate dose possible, there is a mandatory final weight that must be obtained in a medical office within 11-15 calendar days from the scheduled infusion.

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PATIENT INFORMATION:

First, Middle, Last Name _____ Email _____
 Gender ☐ Male ☐ Female DOB (MM/DD/YYYY) _____ Last 4 digits of Social Security # _____ Preferred Language _____
 Street Address _____ City _____ State _____ ZIP _____
 Home Phone (_____) _____ Work (_____) _____ Mobile (_____) _____ Best Time to Contact _____
 Caregiver Name (First and Last) _____ Relationship to Patient _____ Caregiver Phone (_____) _____

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PRESCRIBER INFORMATION:

First and Last Name _____
 State License # _____ NPI # _____ Tax ID # _____
 Facility/Institution Name _____ Street Address _____ City _____ State _____ ZIP _____
 Office Phone (_____) _____ Fax _____ Office Contact Name/Title _____
 Office Contact Phone (_____) _____ Office Contact Email _____
 Shipping/Receiving Contact Name _____ Shipping/Receiving Contact Phone (_____) _____

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FAYUVI (rebisufiligene etisparvovec-hopf) suspension for intravenous infusion Prescription Information

Select ICD-10-CM code below

☐ E76.22 Sanfilippo Mucopolysaccharidosis Subtype: _____ ☐ Other _____

Patient weight _____ kg Date weight taken _____

FAYUVI (rebisufiligene etisparvovec-hopf) suspension Refill: No refills Expected infusion date: _____

☐ Pharmacist will utilize the below weight-based chart to adjust the dose and vial quantity based on the patient's most recent weight obtained in a medical office within 11-15 days of the scheduled infusion date.

Directions: Administer 3.0×10^{13} vector genomes per kilogram (vg/kg) body weight as a single intravenous infusion per Prescribing Information

Please check a box to indicate patient dose. The intravenous dosage is determined by patient body weight

Patient weight range (kg)	Dose volume (mL) ^a	Number of vials	Patient weight range (kg)	Dose volume (mL) ^a	Number of vials
2.5 to 3.0	10	5	26.1 to 28.0	84	42
3.1 to 4.0	12	6	28.1 to 30.0	90	45
4.1 to 5.0	16	8	30.1 to 32.0	96	48
5.1 to 6.0	18	9	32.1 to 34.0	102	51
6.1 to 7.0	22	11	34.1 to 36.0	108	54
7.1 to 8.0	24	12	36.1 to 38.0	114	57
8.1 to 9.0	28	14	38.1 to 40.0	120	60
9.1 to 10.0	30	15	40.1 to 42.0	126	63
10.1 to 12.0	36	18	42.1 to 46.0	138	69
12.1 to 14.0	42	21	46.1 to 50.0	150	75
14.1 to 16.0	48	24	50.1 to 54.0	162	81
16.1 to 18.0	54	27	54.1 to 58.0	174	87
18.1 to 20.0	60	30	58.1 to 62.0	186	93
20.1 to 22.0	66	33	62.1 to 66.0	198	99
22.1 to 24.0	72	36	66.1 to 70.0 ^b	210	105
24.1 to 26.0	78	39			

^a Dose volume is calculated using the upper limit of the patient weight range, rounded up to the nearest 2 mL.
^b Patients weighing >70 kg will be dosed at the 70 kg weight

☐ No Known Drug Allergies (NKDA)

Concurrent Medications _____ Special Precautions (eg, allergies) _____

Special Instructions _____

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

Prescriber Signature (No Stamps) _____ Substitution Permitted Date _____

I authorize Ultragenyx to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan by any means allowed under applicable law

This is an **opt-out box**. Ultragenyx supports patients enrolled in UltraCare with education about their Gene Therapy Journey including the pre- and post-infusion phases through Gene Therapy Guides, who contact patients directly. By checking this box, you are **declining** this service for your patient.

☐ OPT-OUT: UltraCare Gene Therapy Guide to provide the patient and caregiver with pre- and post-infusion adherence education