TRAVERE TotalCare™

FILSPARI® (sparsentan) Start Form and Prescription

Please complete all fields and fax form to 888-381-0625.
Please call 833-FILSPARI (833-345-7727) for assistance.

Please fax the following clinical documentation along with this Start Form:
☐ clinical notes ☐ previous medications ☐ copy of front and back of prescription insurance card

Please refer to FILSPARI-REMS.com for additional information regarding REMS requirements and enrollments. For more information about FILSPARI, please visit FILSPARIhcp.com.
***INDICATES REQUIRED FIELD**

1. PATIENT INFORMATION

Name*: (First) ______ (MI) ___ (Last) ______ Date of Birth*: ____/____/____
Mobile Phone*: (____) ____-______ Home Phone: (____) ____-______ Gender Assigned at Birth: ☐ Male ☐ Female
Shipping Address*: ______ Apt #: ______
City*: ______ State*: ______ ZIP Code*: ______ Email*: ______

2. PATIENT INSURANCE INFORMATION FILL OUT INFORMATION IN SECTION 2 OR ATTACH COPIES OF *FRONT AND BACK* OF PRESCRIPTION INSURANCE CARDS

Prescription Drug Insurance ☐ **Patient does not have insurance**
Primary pharmacy carrier*: ______ Policy Phone*: (____) ____-______
Name of insured (Cardholder)*: ______
Rx Member ID*: ______ Rx Group ID: ______ Rx BIN: ______ Rx PCN: ______

Medical Insurance
Primary insurance carrier: ______ Policy ID: ______ Policy Phone: (____) ____-______

3. PRESCRIBER INFORMATION

Prescriber Name*: ______ Prescriber NPI*: ______
Name of Office*: ______ Prescriber Specialty: ______
Address*: ______ City*: ______ State*: ______ ZIP Code*: ______
Contact Name*: ______ Office Contact Email: ______
Phone*: (____) ____-______ Office Fax*: (____) ____-______ Office Contact Phone (if different): (____) ____-______ ext: ______

4. CLINICAL INFORMATION *ALL INFORMATION IN THIS SECTION REQUIRED TO PREVENT DELAY IN PROCESSING

Diagnosis*: ☐ Primary Immunoglobulin A Nephropathy (IgAN) Has the patient had a kidney biopsy*? ☐ Yes ☐ No
☐ Other: ______ Patient proteinuria level: ______ ☐ g/g ☐ g/day
ICD-10 Code(s)*: ☐ N02.____ (Recurrent and Persistent Hematuria) ☐ N18.____ (Chronic Kidney Disease) ☐ R80.____ (Isolated Proteinuria) ☐ Other ____.____ (Specify ICD Code)

5. PRESCRIPTION

Recommended labeled dosing: **Initiate treatment with Filspari (sparsentan) at 200mg once daily, by mouth. After 14 days, increase to the recommended dose of 400mg once daily, as tolerated.**

This prescription includes both the initiation and maintenance doses.

Commercial Initiation Rx (30 days of therapy) Quantity: 46 tablets
Days 1-14: Filspari (sparsentan) Take one 200mg tablet by mouth once daily
Days 15-30: Filspari (sparsentan) Take two 200mg tablets by mouth once daily
Refills: 0

Commercial Maintenance Rx (30 days of therapy)
Quantity: 30 tablets
Filspari (sparsentan) Take one 400mg tablet by mouth once daily
Refills: ______ (up to 11) Other: ______

☐ **QuickStart PRESCRIPTION**

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.

This prescription includes both the initiation and maintenance doses.

QuickStart Initiation Rx (30 days of therapy)
Days 1-14: Filspari (sparsentan) Take one 200mg tablet by mouth once daily
Days 15-30: Filspari (sparsentan) Take two 200mg tablets by mouth once daily
Refills: 0 Quantity: 46 tablets

QuickStart Maintenance Rx (pending payer decision, additional 30 day supply available, if needed)
Filspari (sparsentan) Take one 400mg tablet by mouth once daily
Refills: 0 Quantity: 30 tablets

6. PRESCRIBER AUTHORIZATION

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 Patient Start Form 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.

I authorize Travere or its affiliated companies or subcontractors, including in-network specialty pharmacies, through Travere TotalCare to forward this prescription electronically, by facsimile, or by mail to the relevant in-network pharmacy for the above-named patient. I also authorize Travere TotalCare to perform any steps necessary to obtain reimbursement for FILSPARI, including but not limited to insurance verification and case assessment.

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***INDICATES REQUIRED FIELD**

Name*: (First) ______________________ (MI) ____ (Last) ______________________ Date of Birth* (mm/dd/yyyy): _____/_____/__________

Mobile Phone*: (_______) _______-___________ Email*:____

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 and Release ("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 Patient Start Form, 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 below, 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 PHI 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;
- Contact the patient's plan(s) about their insurance benefit, coverage status, and product administration (e.g., prescription, dosing, refills);
- Disclose information to the patient's treating physician, healthcare professional, or pharmacist as necessary to resolve the patient's insurance coverage, coding, or reimbursement inquiry. The patient authorizes their insurer, treating physician, healthcare provider, and pharmacist 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;
- Provide financial assistance resources, including copay assistance or free drug programs if I meet program eligibility.
- Contact the patient's insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs (e.g., 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 physician, healthcare provider, or pharmacist; and
- Disclose any PHI obtained from the sources listed above to third parties, if required by law, and/or to conduct surveys, focus groups or interviews related to the patient's diagnosis and the effectiveness of the Program.

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, unless I cancel it sooner by calling 1-833-345-7727 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. For privacy rights and choices specific to California residents, please see Travere's policy at https://travere.com/privacy/california-privacy-policy.

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.

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.

Signature of Patient or Legal Representative*:____ **Date*:** ______________

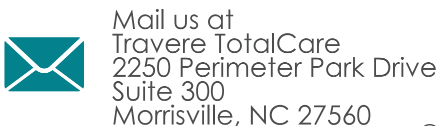
Printed Name of Patient or Legal Representative: ____

Relationship to Patient (if applicable): ____

Preferred Language: ☐ English ☐ Spanish ☐ Other: ________________ Preferred method of contact: ☐ Phone ☐ Email ☐ Text

☐ **By checking this box, I additionally authorize Travere and my Insurer and Treating Providers to contact me by mail, email, telephone, text 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. I acknowledge and agree that the text messages may contain Protected Health Information (PHI). Text messaging is not a secure method of communication and carries some risk of being read by a third party. Messaging and data rates may apply, and terms and privacy information are available at https://travere.com/terms-and-conditions. I may revoke or withdraw this consent at any time. Withdrawal of consent for text messages can be made by replying STOP to the messages.**

Power of Attorney documentation is required if an adult other than the patient signs. You may fax the documents to 1-888-381-0625 or call 1-833-345-7727 for further assistance. NOTE: Enrollment cannot be processed without a valid signature.



Mail us at
Travere TotalCare
2250 Perimeter Park Drive
Suite 300
Morrisville, NC 27560

Call us at
1-833-345-7727
Monday - Friday, 8 AM - 8 PM ET

Fax us at
1-888-381-0625

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