



CHOLBAM® (CHOLIC ACID) CAPSULES

PATIENT ENROLLMENT FORM GUIDE

Use this guide to help you accurately fill out the CHOLBAM Patient Enrollment Form (PEF) to ensure timely processing of your patient's prescription.

Fax completed CHOLBAM Enrollment Forms to 1-855-282-4884.

PATIENT INSURANCE INFORMATION

Your patient's insurance information is needed for Mirum Access Plus (MAP) to verify prescription benefits for CHOLBAM. If available, please provide copies of both sides of your patient's insurance card(s). Alternatively, please encourage your patient to go to CHOLBAM.com to sign up for MAP.

REQUIRED FIELDS

- 1 All fields marked with a (*) are required and must be completed to prevent processing delays.

URGENT PATIENT ACCESS PROGRAM

- 2 Check this box to enroll in the Mirum Urgent Patient Access Program to expedite access to CHOLBAM for eligible patients if a pre-defined access barrier of ≥5 days is experienced.

DIAGNOSIS

- 3 Provide the ICD-10 code that best describes the patient's diagnosis and check the appropriate diagnosis box.

PRESCRIPTION

- 4 This section serves as the actual prescription for CHOLBAM and needs to be fully completed to prevent delays or additional outreach from the pharmacist.

Reference the weight-based dosing table on the PEF or the full Prescribing Information at CHOLBAMHCP.com.

- 5 Specify the number of refills.

PRESCRIBER AUTHORIZATION

- 6 To honor your request for CHOLBAM, please sign only on the DAW line.

mirum access PLUS Navigating Together

CHOLBAM® (CHOLIC ACID) CAPSULES
PATIENT ENROLLMENT FORM
Phone: 1-855-MRM-4YOU | 1-855-676-4968 | Fax: 1-855-282-4884
Monday - Friday: 8:00 am - 8:00 pm ET

Complete this form for all patients. Fields marked with a (*) are required. 1
Fax completed form and copy of patients' insurance card (front and back) to 1-855-282-4884 and/or include copy of patient demo from electronic medical records. Ensure drug benefit card/information is included.

1. PATIENT INFORMATION (please print)

*First name Jane MI _____ *Last name Smith
*Gender M F *Date of birth (MM/DD/YYYY) 08/18/2016 Allergies _____ None
*Address 123 Main Street *City Denver *State CO *ZIP code 80238
Primary guardian/alternate contact full name _____ Relationship _____
*Primary phone (100) 000-0001 Mobile phone _____
Email _____ Primary language _____

2. MEDICAL BENEFITS - PHARMACY BENEFITS (PRESCRIPTION DRUG CARD)

	Primary Medical Benefits	Pharmacy Benefits
Insurance/Payer Name	Medical insurance	Prescription insurance
Insurance/Payer Phone #	800-100-1200	
Subscriber/Policy ID	W1234 56789	
Group #	000111000	
Rx BIN		120000
Rx PCN		ABCD

3. URGENT PATIENT ACCESS PROGRAM 2

By checking this box, I have determined there is an immediate and urgent medical need for CHOLBAM to further this patient's welfare and if there is a pre-determined access barrier of at least five (5) business days, my patient should be evaluated for the Urgent Patient Access Program.
If approved, eligible patients can receive an initial 15-day supply. Patients continuing to experience a pre-defined access barrier, such as coverage determination delays, may be eligible to receive, upon approval, additional 15-day supplies, up to a max 60 days in total.

4. PRESCRIBER INFORMATION (please print)

*First name Maria *Last name Jones
Site/Clinic name Children's Hospital Office contact name Mark Davis
*Address 123 Medical Way *City Denver *State CO *ZIP code 80238
*Office contact phone (100) 000-0001 *Fax (100) 000-0006 Email MarkDavis@email.com
*Prescriber NPI# 0000000001 *Specialty Pediatric Gastroenterology State license number _____

5. DIAGNOSIS/MEDICAL INFORMATION (This is for insurance purposes only, not to suggest approved uses for indication)

3 Diagnosis: Bile Acid Synthesis Disorders (B.A.S.D.) ICD-10-CM Code: A00.0 ICD-10-CM Code/Description: _____

Due to Single Enzyme Defect (check box):
 Smith Lemli-Opitz Syndrome (SLOS) CYP27A1 deficiency (presenting as cerebrotendinous xanthomatosis, CTX) Unknown/Other
 3β-HSD or HSD3β7 deficiency
 AKR1D1 deficiency AMACR deficiency

Due to Peroxisomal Biogenesis Disorder: Zellweger Spectrum Disorder (PBD-ZSD):
 PBD-ZSD - Severe Unknown/Other
 PBD-ZSD - Mild - Moderate

6. *PRESCRIPTION (please print)

4 CHOLBAM (cholic acid) Instructions for use _____
CHOLBAM Total daily dose = XX mg/day; XX mg by mouth XX times a day
(The recommended dosage of CHOLBAM is 10 to 15 mg/kg per day administered orally in two divided doses. Refer to the PI for additional information on Dosage & Administration)
Dosing Weight (kg) 23 Quantity = QS for 30 Days Supply Refills 11 5

7. *PRESCRIBER AUTHORIZATION

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. I have made the determination, based on my independent clinical judgment, that the medication ordered is medically appropriate for the patient for the intended use. I am personally supervising the care of this patient. I authorize Mirum Pharmaceuticals, Inc., its affiliates, agents, and contractors (collectively, "Mirum") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy. This authorization includes permitting Mirum to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits.

X Prescriber Signature 6 (Dispense as Written) _____ (Substitution Permitted) _____ Date _____
Written signature only, stamps not acceptable.

PATIENT AUTHORIZATION

- 7 Patients who opt-in can receive additional, enhanced communications and resources from MAP to support them along their treatment journey.
- 8 The patient authorization is located on the second page of the PEF. The authorization is required for MAP to provide optional patient services. If the patient/authorized patient representative is not available to sign the form at your office, your patient can go to CHOLBAM.com to sign up for MAP services.

INDICATION

CHOLBAM® (cholic acid) is a bile acid indicated for

- Treatment of bile acid synthesis disorders due to single enzyme defects.
- Adjunctive treatment of peroxisomal disorders, including Zellweger spectrum disorders, in patients who exhibit manifestations of liver disease, steatorrhea, or complications from decreased fat-soluble vitamin absorption.

LIMITATIONS OF USE

The safety and effectiveness of CHOLBAM on extrahepatic manifestations of bile acid synthesis disorders due to single enzyme defects or peroxisomal disorders, including Zellweger spectrum disorders, have not been established.


IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS -

Exacerbation of liver impairment

- Monitor liver function and discontinue CHOLBAM in patients who develop worsening of liver function while on treatment.
- Concurrent elevations of serum gamma glutamyltransferase (GGT) and alanine aminotransferase (ALT) may indicate CHOLBAM overdose.
- Discontinue treatment with CHOLBAM at any time if there are clinical or laboratory indicators of worsening liver function or cholestasis.

Please see full Prescribing Information for CHOLBAM.



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8. PATIENT AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION AND MIRUM COMMUNICATIONS

Authorization to Share Protected Health Information

By signing this authorization, I (or my representative) authorize my healthcare providers, health plans, and pharmacies (collectively, "Healthcare Organizations") to use and share my personal and health information related to my medical condition, treatment, and insurance coverage (my "health information") with Mirum Pharmaceuticals, Inc., its affiliates, agents, and representatives (collectively, "Mirum") (i) to contact me or my healthcare organizations, or others I have identified, about my disease or treatment, (ii) to work with my insurance carrier and other potential funding sources to try to help me get coverage, reimbursement, or payment for the medication ordered by my prescriber, (iii) for referral to and enrollment in patient support and/or financial assistance programs, (iv) to work with third parties to provide community resources and referrals, (v) for providing me with materials, information, and services related to my drug therapy and ways to help me maintain my prescribed treatment, (vi) for market research purposes, (vii) to improve, develop, and evaluate products, services, programs, or treatments related to my disease, (viii) to use aggregated de-identified data for research or publications, or (ix) as required or permitted by law. I understand that, once disclosed pursuant to this authorization, my health information may no longer be protected under federal or state law and could be disclosed to others, but I understand that Mirum will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization. I understand that my pharmacy may be paid to share my information with Mirum as allowed under this authorization.

Mirum Communications

I authorize Mirum to contact me by mail, telephone (including voicemail), or email for education and marketing purposes, including contacting me for market research purposes about Mirum therapies or Mirum. I understand and agree that any information that I provide may be used by Mirum to help develop new products, services, and programs. I agree and understand that my authorization is voluntary and that neither Mirum nor any of my healthcare providers, health plans, and pharmacies may condition my treatment, payment for treatment, enrollment or eligibility for benefits, including my eligibility to receive Mirum products, on whether I provide my authorization. However, if I do not provide authorization, I will not be able to receive the Mirum services and support described above. I understand that this authorization will remain valid for 10 years after the date set forth below or such earlier date as required by applicable law, unless I revoke it earlier by cancelling my enrollment in writing, which I may do at any time by contacting Mirum's representative at privacy@mirumpharma.com. I understand that my cancellation will not apply to any use or disclosure of my health information by my healthcare providers, health plans, or pharmacies before they receive notice of my cancellation. I understand I have a right to receive a copy of this authorization.

7 By checking this box, I consent to receiving support, reminder, and educational text messages from Mirum to my mobile phone number. Standard text messaging rates will apply.

*Mobile phone _____


Print Patient or Authorized Patient Representative Name _____

8 Signature of Patient or Authorized Patient Representative _____

If Representative, Relationship to Patient:

Parent/Legal Guardian Representative per Power of Attorney Spouse

Date _____



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