TRAVERE THERAPEUTICS

CHENODAL® (Chenodiol Tablets 250 mg)

Patient Enrollment Form for CHENODAL® Total Care Hub

Phone: 866-758-7068 — Fax: 866-564-9497

PATIENT INFORMATION

Patient First Name			MI
Last Name		Gender	☐ M ☐ F
Date of Birth	SS#		
Height_____ inches	Weight _____ kgs		
Address			
City	State	ZIP	
Home Phone	Mobile Phone		
Preferred Method of Contact ☐ Home Phone ☐ Mobile Phone ☐ E-mail			
E-mail			

FOR PATIENTS UNDER 18:
Parent/Guardian

First Name			MI
Last Name			
Address			
City	State	ZIP	
Home Phone	Mobile Phone		
E-mail			

PRIMARY INSURANCE Please attach a copy of both sides of the patient's insurance card(s)

Insurance Carrier
Customer Service Phone
Subscriber Name
Relationship to Patient
Employer Name
Subscriber Date of Birth
Subscriber ID Number
Policy/Employer/Group Number

PHARMACY BENEFITS–PRESCRIPTION DRUG CARD

Insurance Carrier	
Customer Service Phone	
Subscriber Name	Bin#
Subscriber Date of Birth	
Subscriber ID Number	
Policy/Employer/Group Number	

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

Diagnosis: _____ ICD-10-CM Code: _____ ICD-10-CM Code/Description _____

CHENODAL (chenodiol tablets) ORAL CAPSULES PRESCRIPTION/ORDER

CHENODAL Total daily dose =_____ mg/day: _____mg _____times a day
(The recommended dosage range of CHENODAL for gallstones is 13 to 16 mg/kg/day administered in two, divided doses, morning and night. Refer to the PI for additional information on Dosage & Administration)

Dispense 30 day supply **Number of refills** _____

Signature:_____

Lab Test Supporting Diagnosis	Results (at least one result)	Date
Genetic Test		
FAB-MS, Urinary Bile Acid (Atypical)		
Cholestanol		
7A12AC4 or 7AC4, Ketosterols		
Liver Function (ALT/AST/GGT/Bilirubin)		
Amylase and/or Lipase		
Other: _____		

PHYSICIAN CERTIFICATION

By signing below, I certify that (a) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly; (b) I have received the necessary authorizations, including those required by state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to release the above information and other health and medical information of the patient to Travere Therapeutics, Inc., and the company or companies that help Travere Therapeutics administer the CHENODAL Total Care Hub services; (c) I am prescribing the drug listed for the patient listed in this application based upon my independent medical judgment. By my signature below, I agree to receive certain reimbursement support services. I authorize Travere Therapeutics and EVERSANA, acting on behalf of Travere Therapeutics, to use the information contained in the prescription above, my name, and the name, address, and telephone number of my medical practice, and other applicable information, in order to provide me, my practice, and the patient listed in this application with the aforementioned reimbursement support services. I understand that participation in the CHENODAL Total Care Hub services described does not constitute a guarantee on the part of Travere Therapeutics or parties acting on its behalf that (1) the drug I have prescribed will be reimbursed by the patient's or any insurance program, or (2) the patient will be eligible for any patient assistance program. I appoint Travere Therapeutics and its agents to convey this prescription— electronically or otherwise—to the dispensing pharmacy.

Prescriber's Signature		Date	
Prescriber NPI#		Prescriber State License #	

Prescriber's full, usual, and actual signature is required – no stamps. This form cannot be processed without the prescriber's signature.

Prescriber's First Name		MI	Last Name		
Address	City			State	ZIP
Phone	Fax			E-mail	
Office Contact Name		Phone			

Please note: If you are faxing a prescription, it must be faxed from prescriber's facility to fax number (866) 564-9497.

Please return this form to the CHENODAL (chenodiol tablets) Total Care Hub by faxing it to (866) 564-9497.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

Before signing, the patient and/or patient's authorized representative should review and understand the terms of this Authorization and Release ("Authorization") before signing. 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 Enrollment Form, such as the patient's name, address, insurance, prescription, and medical information, is "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.

I understand that I may decline to sign this Authorization, and that doing so will not affect the patient's ability to receive CHENODAL® (chenodiol tablets) or obtain insurance or insurance benefits

I understand that once PHI about the patient is released, based on this Authorization, federal privacy laws may not prevent Travere Therapeutics and company or companies who help administer the CHENODAL® Total Care Hub Support Services ("Services") from further disclosing my 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. I also understand that I may revoke (withdraw) this Authorization at any time by sending a signed, written statement to the CHENODAL® Total Care Hub and faxing it to (866) 564-9497.

Revoking this Authorization will prohibit PHI disclosures after the date the written revocation is received by the CHENODAL® Total Care Hub, except to the extent that action has been taken already in on this Authorization. After I revoke this Authorization, the patient's PHI may be disclosed among Travere Therapeutics and the company or companies that help Travere Therapeutics administer the Services in order to maintain records of the patient's participation, but it will not be otherwise disclosed or used.

By signing below, I authorize Travere Therapeutics and the company or companies that help Travere Therapeutics administer the Services, to do the following:

1. Request and receive information from the patient's treating physician, healthcare provider, health insurer, or pharmacist 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;
2. Collect, use, and disclose to each other any patient information including PHI provided to Travere Therapeutics 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 PHI in a database;
3. 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 CHENODAL, including nutritional support and counseling;
4. Communicate with my healthcare providers and health plans about my benefit and coverage status and product administration (e.g., prescription, dosing, refills);
5. Disclose information to the patient's treating physician, healthcare professional, or pharmacist that I have provided to Travere Therapeutics as necessary to resolve patient insurance coverage, coding, or reimbursement inquiry. By signing below, I also authorize the insurer, treating physician, healthcare provider, and pharmacist to release PHI about the patient's prescribed medications and medical condition requested by Travere Therapeutics and the company or companies that help Travere Therapeutics administer the Services.
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6. Contact the patient's insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs (e.g., the CHENODAL® Total Care Hub) 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
7. Disclose any PHI obtained from the sources listed above to third parties, if required by law, and to conduct surveys to evaluate the effectiveness of the CHENODAL® Total Care Hub program.

Travere Therapeutics and Services administer agree to protect the patient's PHI by using and disclosing the patient's PHI only for the reasons listed above or as required by law

Patient's Signature		**Date**	

Print Patient's Name

Legally Authorized Representative's Signature (if needed)

Print Legally Authorized Representative's Name

Relationship to Patient ☐ **Spouse** ☐ **Legal Guardian** ☐ **Representative per Power of Attorney**

Representative's Address

Phone **Mobile Phone**

Fax this form, along with both sides of the patient's Medical and Prescription Drug Benefit cards to CHENODAL® Total Care Hub at (866) 564-9497.
Retain a copy of this form in the patient's records.