OnePath® Start Form

Phone: 1-866-888-0660 Fax: 1-888-990-0008

Recommending / Prescribing Physician

Name (First, Last) | Office Contact

Site Name

Street Address

City | State | Zip Code

( ) Telephone | ( ) Fax

Tax ID # | State License # | National Provider #

Site of Care Information

Name (First, Last) | Office Contact

Site Name | National Provider ID #

Street Address

City | State | Zip Code

( ) Telephone | ( ) Fax

Please provide administering physician's UPIN or Provider ID# with patient's insurer(s):

Patient Information

Name (First , Middle Initial, Last) ☐ Male ☐ Female DOB: Month Day Year Social Security #

Street Address | City | State | Zip Code | Contact Name and Relationship to Patient

E-mail Address | ( ) Home Telephone | Best Time to Contact | ( ) Work Telephone | Best Time to Contact | ( ) MobileTelephone

Insurance Information - Please attach copies of both sides of patient's insurance card(s) ☐ Check if patient does not have insurance

Primary Insurance | ( ) Insurance Telephone | Policy # | Group # | Policy Holder Name (First, Last) and Relationship to Patient

Secondary Insurance | ( ) Insurance Telephone | Policy # | Group # | Policy Holder Name (First, Last) and Relationship to Patient

Product Information

Please indicate the Shire product: ☐ ELAPRASE®(idursulfase) ☐ VPRIV® (velaglucerase alfa for injection)

Physician Authorization

I confirm that the Recommending / Prescribing Physician information provided above is accurate.

Prescriber Signature (stamps not acceptable) _____ Date _____

Patient Authorization to Share Personal Health Information

I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Health Care Providers") to disclose my personal health information, including information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to Shire Human Genetic Therapies, Inc., its affiliates and their representatives, agents, and contractors (collectively, "Shire") and to receive financial remuneration from Shire in exchange, for the following purposes: for Shire to provide product support services, including coordination of benefits and therapy; reimbursement support; investigating insurance coverage; communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance; and internal use by Shire, including data analysis. I understand that my Personal Health Information disclosed under this authorization may be re-disclosed by Shire and no longer protected by federal privacy laws. I understand, however, that Shire agrees to undertake reasonable efforts to maintain my Personal Health Information in a secure manner and not to disclose it to third parties without a legitimate reason for doing so. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits, including my access to therapy, is not conditioned on my signing this Authorization. I understand that I am entitled to a signed copy of this Authorization. This Authorization expires one year from the date of execution, or one year after the date of my last prescription, whichever is later. I understand that I may revoke this Authorization at any time by sending written notice of revocation to OnePath®, 300 Shire Way, Lexington, MA 02421, which becomes effective upon receipt by any Health Care Provider subject to federal privacy laws, except to the extent that action already has been taken in reliance on this Authorization.

Patient Signature _____ Date _____

(if Patient is a minor) Parent/Guardian/Legal Representative Name (please print) _____ Relationship to Patient _____

Parent/Guardian/Legal Representative Signature _____ Date _____

Patient Authorization for Shire's OnePath Services

I certify that all of the information provided on this form is complete and accurate. I authorize Shire to provide product support services, including but not limited to coordination of benefits and therapy; reimbursement support; investigating insurance coverage; communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance.

Patient Signature _____ Date _____

Parent/Guardian/Legal Representative Signature _____ Date _____

Please see accompanying full Prescribing Information including Boxed Warning (ELAPRASE®(idursulfase))