LIVMARLI® (MARALIXIBAT) ORAL SOLUTION

PATIENT ENROLLMENT FORM GUIDE

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

Fax completed LIVMARLI 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 LIVMARLI. If available, please provide copies of both sides of your patient's insurance card(s). Alternatively, please encourage your patient to go to LIVMARLI.com to sign up for MAP and provide their insurance information via their mobile phone.

REQUIRED FIELDS

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

DIAGNOSIS

2. There is no ICD-10 code specifically for Alagille syndrome. Provide the ICD-10 code that best describes the patient's diagnosis.

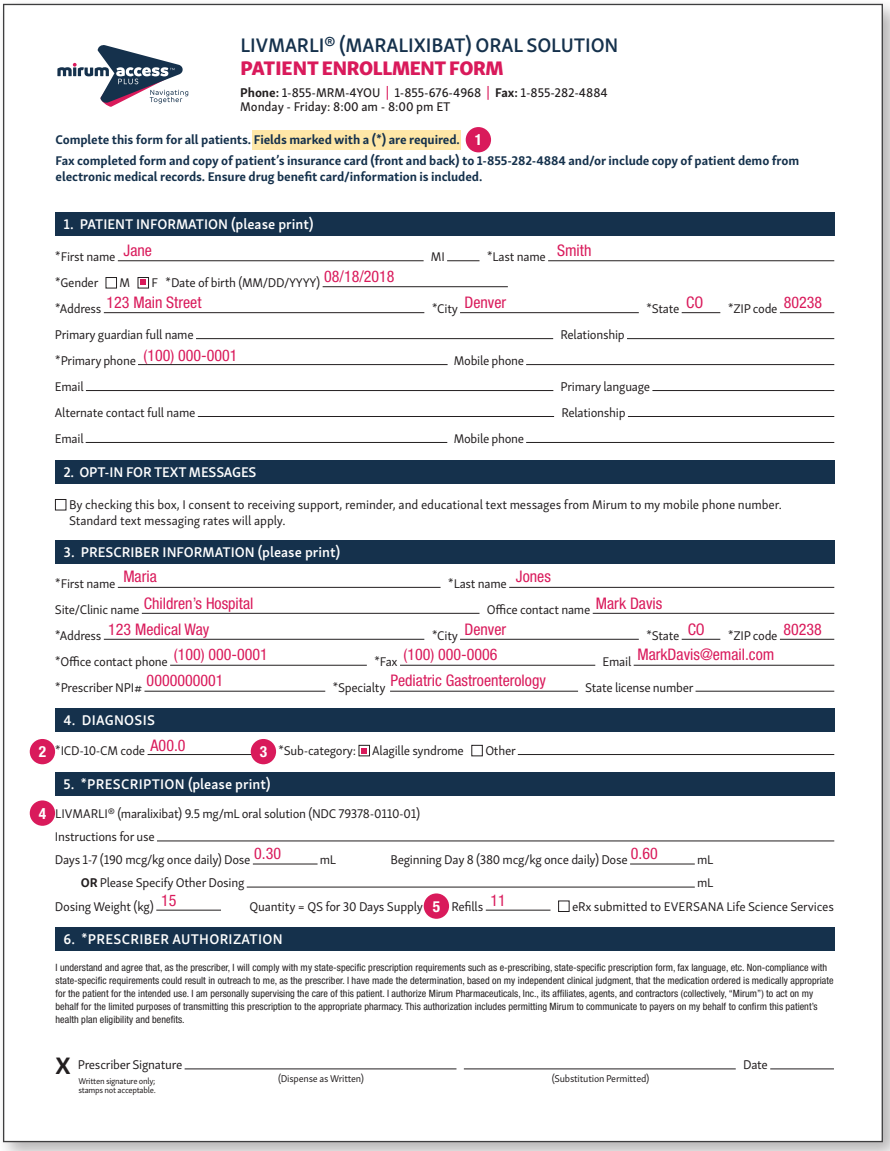
3. Be sure to select a diagnosis sub-category. Note: Certain MAP services may be limited to patients with Alagille syndrome.

PRESCRIPTION

4. This section serves as the actual prescription for LIVMARLI 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 LIVMARLIHCP.com.

5. Specify the number of refills. Note: Some Medicaid insurers will only allow a maximum of 5 refills.



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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 patient's 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) 08/18/2018
*Address 123 Main Street *City Denver *State CO *ZIP code 80238
Primary guardian full name ____ Relationship ____
*Primary phone (100) 000-0001 Mobile phone ____
Email ____ Primary language ____
Alternate contact full name ____ Relationship ____
Email ____ Mobile phone ____

2. OPT-IN FOR TEXT MESSAGES

☐ 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.

3. 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 ____

4. DIAGNOSIS

2 *ICD-10-CM code A00.0 3 *Sub-category: ☒ Alagille syndrome ☐ Other ____

5. *PRESCRIPTION (please print)

4 LIVMARLI® (maralixibat) 9.5 mg/mL oral solution (NDC 79378-0110-01)
Instructions for use ____
Days 1-7 (190 mcg/kg once daily) Dose 0.30 mL Beginning Day 8 (380 mcg/kg once daily) Dose 0.60 mL
OR Please Specify Other Dosing ____ mL
Dosing Weight (kg) 15 Quantity = QS for 30 Days Supply 5 Refills 11 ☐ eRx submitted to EVERSANA Life Science Services

6. *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 ____ ____ Date ____
Written signature only; stamps not acceptable. (Dispense as Written) (Substitution Permitted)

Guide instructions continued on page 2

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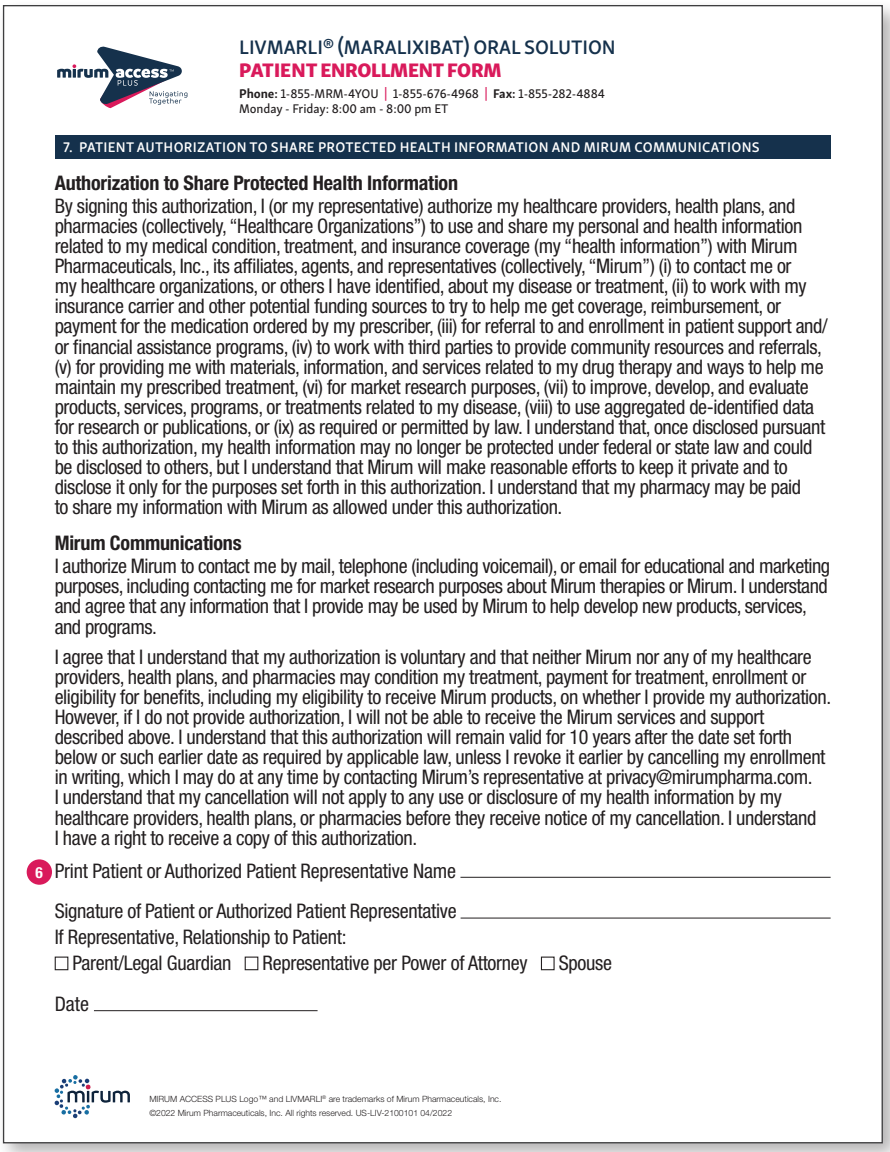
PATIENT AUTHORIZATION

6 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 LIVMARLI.com to sign up for MAP services via their mobile phone.



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7. 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 educational 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 that I 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.

6 Print Patient or Authorized Patient Representative Name _____

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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INDICATION

LIVMARLI is indicated for the treatment of cholestatic pruritus in patients with Alagille syndrome (ALGS) 1 year of age and older.

IMPORTANT SAFETY INFORMATION

Warnings:

Liver Test Abnormalities: Obtain baseline liver tests and monitor during treatment. Dose reduction or treatment interruption may be considered if abnormalities occur.

Gastrointestinal Symptoms: Consider interrupting treatment if a patient experiences persistent diarrhea, abdominal pain, vomiting, or has diarrhea with bloody stool, vomiting, dehydration requiring treatment, or fever.

Fat-Soluble Vitamin (FSV) Deficiency: Obtain baseline levels and monitor during treatment. Supplement vitamins if deficiency is observed.

Please see accompanying full Prescribing Information for LIVMARLI in pocket.