LIVMARLI™ (MARALIXIBAT) ORAL SOLUTION
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.

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 _____ MI _____ *Last name _____

*Gender ☐ M ☐ F *Date of birth (MM/DD/YYYY) _____

*Address _____ *City _____ *State _____ *ZIP code _____

Primary guardian full name _____ Relationship _____

*Primary phone _____ 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 _____ *Last name _____

Site/Clinic name _____ Office contact name _____

*Address _____ *City _____ *State _____ *ZIP code _____

*Office contact phone _____ *Fax _____ Email _____

*Prescriber NPI# _____ *Specialty _____ State license number _____

4. DIAGNOSIS

*ICD-10-CM code _____ *Sub-category: ☐ Alagille syndrome ☐ Other _____

5. *PRESCRIPTION (please print)

LIVMARLI™ (maralixibat) 9.5 mg/mL oral solution (NDC 79378-0110-01)

Instructions for use _____

Days 1-7 (190 mcg/kg once daily) Dose _____ mL Beginning Day 8 (380 mcg/kg once daily) Dose _____ mL

OR Please Specify Other Dosing _____ mL

Dosing Weight (kg) _____ Quantity = QS for 30 Days Supply Refills _____ ☐ 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)

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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.

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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Individual Dose Volume by Patient Weight

Patient Weight (kg)	Days 1-7 (190 mcg/kg once daily) Volume QD (mL)	Beginning Day 8 (380 mcg/kg once daily) Volume QD (mL)
5 to 6	0.1	0.2
7 to 9	0.15	0.3
10 to 12	0.2	0.45
13 to 15	0.3	0.6
16 to 19	0.35	0.7
20 to 24	0.45	0.9
25 to 29	0.5	1
30 to 34	0.6	1.25
35 to 39	0.7	1.5
40 to 49	0.9	1.75
50 to 59	1	2.25
60 to 69	1.25	2.5
70 or higher	1.5	3