LIVMARLI® (MARALIXIBAT) ORAL SOLUTION AND TABLETS
PATIENT ENROLLMENT FORM FOR ALAGILLE SYNDROME

mirum access PLUS Navigating Together

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) _____ Allergies _____ ☐ None

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

Primary guardian/alternate contact full name _____ Relationship _____

*Primary phone _____ Mobile phone _____

Email _____ Primary language _____

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

	Primary Medical Benefits	Pharmacy Benefits
Insurance/Payer Name		
Insurance/Payer Phone #		
Subscriber/Policy ID		
Group #		
Rx BIN		
Rx PCN		

3. URGENT PATIENT ACCESS PROGRAM

☐ By checking this box, I have determined there is an immediate and urgent medical need for LIVMARLI to further this patient's welfare and if there is a pre-defined 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 _____ *Last name _____

Site/Clinic name _____ Office contact name _____

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

*Office contact phone _____ *Fax _____ Email _____

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

5. DIAGNOSIS

*ICD-10-CM code _____

*Sub-category: ☐ Alagille syndrome (ALGS) ☐ Progressive familial intrahepatic cholestasis (PFIC) - See page 3 for PFIC form

☐ Other _____

6. *PRESCRIPTION (please print) SEE PAGE 2 FOR WEIGHT-BASED DOSING TABLE

LIVMARLI® (maralixibat) **9.5 mg/mL oral solution** (NDC 79378-110-01)
LIVMARLI® (maralixibat) **10 mg, 15 mg, 20 mg, 30 mg tablet** (NDC 79378-210-30, NDC 79378-215-30, NDC 79378-220-30, NDC 79378-230-30)

Dosing Weight (kg, to nearest whole number) _____

Titration Dosing – Days 1-7
Formulation (check one): ☐ Solution ☐ Tablet
Dosage (check one):
The total mgs or mLs per dose based on selected dosage and corresponding weight range is shown in the dosing table on page 2.
☐ 190 mcg/kg once daily *(recommended)*
☐ Other (specify below)

Maintenance Dosing – Days 8+
Formulation (check one): ☐ Solution ☐ Tablet
Dosage (check one):
The total mgs or mLs per dose based on selected dosage and corresponding weight range is shown in the dosing table on page 2.
☐ 380 mcg/kg once daily *(recommended)*
☐ Other (specify below)

If Other Dosing, please specify _____
Quantity = QS for 30 days supply Refills _____

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 _____ _____ Date _____

Written signature only; stamps not acceptable.

(Dispense as Written) (Substitution Permitted)

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PATIENT ENROLLMENT FORM FOR ALAGILLE SYNDROME

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Table 1: 9.5 mg/mL Oral Solution for Patients With ALGS: Volume per Dose (mL) by Weight

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

Table 2: Tablets for Patients With ALGS: Dosage by Weight

Patient Weight (kg)	Days 1-7 (190 mcg/kg once daily)	Beginning Day 8 (380 mcg/kg once daily)
Less than 25	Use Oral Solution	Use Oral Solution
25 to 32		10 mg
33 to 43		15 mg
44 to 65	10 mg	20 mg
66 or higher	15 mg	30 mg

Select the appropriate product based on the patient's weight and ability to swallow tablets.

LIVMARLI® (MARALIXIBAT) ORAL SOLUTION AND TABLETS

PATIENT ENROLLMENT FORM FOR PROGRESSIVE FAMILIAL INTRAHEPATIC CHOLESTASIS

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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) _____ Allergies _____ ☐ None

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

Primary guardian/alternate contact full name _____ Relationship _____

*Primary phone _____ Mobile phone _____

Email _____ Primary language _____

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

	Primary Medical Benefits	Pharmacy Benefits
Insurance/Payer Name		
Insurance/Payer Phone #		
Subscriber/Policy ID		
Group #		
Rx BIN		
Rx PCN		

3. URGENT PATIENT ACCESS PROGRAM

☐ By checking this box, I have determined there is an immediate and urgent medical need for LIVMARLI to further this patient's welfare and if there is a pre-defined 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 _____ *Last name _____

Site/Clinic name _____ Office contact name _____

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

*Office contact phone _____ *Fax _____ Email _____

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

5. DIAGNOSIS

*ICD-10-CM code _____

*Sub-category: ☐ Alagille syndrome - See page 1 for ALGS form ☐ Progressive familial intrahepatic cholestasis (PFIC) type (specify protein) _____

☐ Other _____

6. *PRESCRIPTION (please print) SEE PAGE 4 FOR WEIGHT-BASED DOSING TABLE

LIVMARLI® (maralixibat) **19 mg/mL oral solution** (NDC 79378-111-01)
LIVMARLI® (maralixibat) **10 mg, 15 mg, 20 mg, 30 mg tablet** (NDC 79378-210-30, NDC 79378-215-30, NDC 79378-220-30, NDC 79378-230-30)

Dosing Weight (kg, to nearest whole number) _____

Titration Dosing

Formulation (check one): ☐ Solution ☐ Tablet

Dosage (check where applicable):

The total mgs or mLs per dose based on selected dosage and corresponding weight range is shown in the dosing table on page 4.

- ☐ 285 mcg/kg once daily for _____ Days
- ☐ 285 mcg/kg twice daily for _____ Days
- ☐ 428 mcg/kg twice daily for _____ Days
- ☐ Other (specify below)

Maintenance Dosing

Formulation (check one): ☐ Solution ☐ Tablet

Dosage (check one):

The total mgs or mLs per dose based on selected dosage and corresponding weight range is shown in the dosing table on page 4.

- ☐ 570 mcg/kg twice daily *(recommended)*
- ☐ Other (specify below)

If Other Dosing, please specify _____

Quantity = QS for 30 days supply Refills _____

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 _____ _____ Date _____

Written signature only; stamps not acceptable.

(Dispense as Written) (Substitution Permitted)

Table 3: 19 mg/mL Oral Solution for Patients With PFIC: Volume per Dose (mL) by Weight

Patient Weight (kg)	285 mcg/kg (once daily titrated to twice daily)	428 mcg/kg (twice daily)	570 mcg/kg (twice daily as tolerated)
	19 mg/mL Solution (for PFIC) Volume per Dose (mL)		
5	0.1 mL	0.1 mL	0.15 mL
6 to 7	0.1 mL	0.15 mL	0.2 mL
8	0.1 mL	0.2 mL	0.25 mL
9	0.15 mL	0.2 mL	0.25 mL
10 to 12	0.15 mL	0.25 mL	0.3 mL
13 to 15	0.2 mL	0.3 mL	0.4 mL
16 to 19	0.25 mL	0.4 mL	0.5 mL
20 to 24	0.3 mL	0.5 mL	0.6 mL
25 to 29	0.4 mL	0.6 mL	0.8 mL
30 to 34	0.45 mL	0.7 mL	0.9 mL
35 to 39	0.6 mL	0.8 mL	1 mL
40 to 49	0.6 mL	0.9 mL	1 mL
50 to 59	0.8 mL	1 mL	1 mL
60 or higher	0.9 mL	1 mL	1 mL

Table 4: Tablets for Patients With PFIC: Dosage by Weight

Patient Weight (kg)	285 mcg/kg (once or twice daily)	428 mcg/kg (twice daily)	570 mcg/kg (twice daily)
Less than 25	Use Oral Solution	Use Oral Solution	Use Oral Solution
25 to 32			15 mg
33 to 43	10 mg	15 mg	20 mg
44 or higher	15 mg	20 mg	20 mg

Select the appropriate product based on the patient's weight and ability to swallow tablets.

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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.

☐ 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 _____

Signature of Patient or Authorized Patient Representative _____

If Representative, Relationship to Patient:

☐ Parent/Legal Guardian ☐ Representative per Power of Attorney ☐ Spouse

Date _____