decīphera AccessPoint™

Deciphera AccessPoint™ Enrollment Form

PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 1-833-DCPH-FAX (1-833-327-4329).

For assistance, call Deciphera AccessPoint at 1-833-4DACCES (1-833-432-2237), Monday–Friday 8AM–8PM Eastern Time (ET).

1. PATIENT INFORMATION

First Name: ____________ Last Name: ____________

Date of Birth (MM/DD/YYYY): ____________

Gender: Male Female

Street Address: ____________

City: ____________ State: ______ ZIP: ______

Primary Phone: ____________ Secondary Phone: ____________

Email (optional): ____________

Primary Language: English Spanish Other: ____________

Preferred Contact Method: Call Email Text

Best Time to Contact: Morning Afternoon Evening

Care Partner Name: ____________

Care Partner Phone: ____________

2. INSURANCE INFORMATION

NOTE: Please attach a copy of both sides of the patient's insurance card(s).

Coverage: Medicare Medicaid Commercial / Private Other Uninsured

Primary Prescription Insurance: ____________

Phone: ____________ Policy ID: ____________

Group Number: ____________ BIN Number: ____________

PCN Number: ____________ Policy Holder Name: ____________

Policy Holder Date of Birth: ____________

Policy Holder's Relationship to Patient: ____________

Secondary Prescription Insurance: ____________

Phone: ____________ Policy ID: ____________

Group Number: ____________ BIN Number: ____________

PCN Number: ____________ Policy Holder Name: ____________

Policy Holder Date of Birth: ____________

Policy Holder's Relationship to Patient: ____________

3. CLINICAL INFORMATION

Primary Diagnosis ICD-10: ____________

Secondary Diagnosis ICD-10: ____________

Prior Tyrosine Kinase Inhibitor (TKI) Therapies Received:

1st line	2nd line	3rd line
____________	____________	____________
Therapy Name	Therapy Name	Therapy Name

Current Medication(s) (list all): ____________

OR Current Medication List Included/Attached

Known Drug Allergies: ____________

Clinical Notes Included/Attached

4. PATIENT FINANCIAL INFORMATION (required to verify eligibility for assistance)

Number of Household Members (including applicant): ____________

Annual Gross Household Income: $ ____________

1-833-4DACCES (1-833-432-2237)

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5. PRESCRIBER INFORMATION

Prescriber Name (first, last): ____________

Prescriber Title: ____________ Prescriber Specialty: ____________

NPI Number: ____________ DEA Number: ____________

Site / Facility Name: ____________

Street Address: ____________

City: ____________ State: ______ ZIP: ______

Office Contact: ____________

Phone: ____________ Fax: ____________

Email: ____________

Preferred Contact Method: Phone Email Fax

6. PRESCRIPTION FOR QINLOCK™ (ripretinib)

QINLOCK (ripretinib) Rx Refills: ______

50 mg tablets, 90-count bottle (30-day supply)

Recommended dose: 150 mg (3 tablets by mouth once daily)

Alternate dose: ____________

Sign here: ____________ Date: ____________

Prescriber Signature (no stamps)

QINLOCK (ripretinib) Rapid Start Rx Refills: Up to 5

50 mg tablets, 30-count bottle (10-day supply)

Select for a new patient, not yet on therapy, in the event of an insurance-related delay

Recommended dose: 150 mg (3 tablets by mouth once daily)

Alternate dose: ____________

Rapid Start: Patients with private or government insurance receive 10-day supplies of QINLOCK™ (ripretinib), up to 60 days, in event of a delay in insurance coverage investigations. Patients must have an on-label prescription and must not seek reimbursement or credit for this prescription from any insurer, health plan, or provider. By signing below, I certify that I understand the Rapid Start program terms and agree that I shall not seek reimbursement for QINLOCK™ (ripretinib) dispensed through the Rapid Start program.

QINLOCK (ripretinib) Bridge Rx Refills: Up to 5

50 mg tablets, 30-count bottle (10-day supply)

Select for a patient who has already been on therapy, in the event of coverage interruption

Recommended dose: 150 mg (3 tablets by mouth once daily)

Alternate dose: ____________

Sign here: ____________ Date: ____________

Prescriber Signature (no stamps)

All, please note: My signature certifies that the person named on this form is my patient, the information provided, to the best of my knowledge, is complete and accurate, and that therapy with QINLOCK™ (ripretinib) is medically necessary. I certify that I have obtained my patient's written authorization in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Deciphera and Deciphera AccessPoint patient support program and I understand that the information that I provide on this form will be used by the program for purposes of verifying my patient's insurance coverage and eligibility; coordinating the dispensing of my patient's prescription medicine; and introducing Deciphera AccessPoint for QINLOCK™ (ripretinib) support services to my patient, including contacting my patient by telephone or mail for these purposes. I authorize Deciphera AccessPoint for QINLOCK™ (ripretinib) to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Deciphera products and that I have not received nor will I receive any benefit from Deciphera for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by Deciphera AccessPoint.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

7. PREFERRED SPECIALTY PHARMACY

Preferred Specialty Pharmacy selection will be honored if permitted by patient's insurance plan.

Biologics US Bioservices PANTHERx Rare Pharmacy Eligible In-office Dispensing Site

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ENROLLMENT CONSENT AND PRIVACY AUTHORIZATION

CONSENT FOR ENROLLMENT IN DECIPHERA ACCESSPOINT AND PATIENT ASSISTANCE PROGRAM

By signing below, I am enrolling in Deciphera AccessPoint for QINLOCK™ (ripretinib) patient support program (the "Program"). I authorize Deciphera Pharmaceuticals and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Deciphera Pharmaceuticals, "Deciphera") to provide me with services for which I am eligible under the Program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to my enrollment in the copay assistance program if I am eligible. If I am applying for patient assistance (no-cost medication) I authorize the Program to use my personal information to obtain a report on my individual credit history from consumer reporting agencies and use that report and other information collected from public and other sources to verify the information on this form and estimate my income to decide if I am eligible for free medication. Upon request, the Program will provide me the name and address of the consumer reporting agency that provides the consumer report.

I understand that free product programs (Rapid Start, Bridge, or Patient Assistance Program) are subject to eligibility criteria and that completing this application does not ensure that I will qualify for these programs. I certify that all the information provided in this application, including household income, is complete and accurate.I understand that program assistance will terminate if the program becomes aware of any fraud. If I receive free product, I will not seek reimbursement for it from any insurer, health plan, or government program. If I receive free product, I will not seek to have this prescription or any associated cost counted as part of my out-of-pocket cost for prescription drugs.

If signed by a patient representative:

Sign here: ______________________ Date: __________ ______________________ ______________________

Signature of Patient or Patient Representative — Printed Name — Phone Number of Patient Representative

AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, I authorize my health care providers and staff, my pharmacies, and my health insurers to use and to disclose to Deciphera Pharmaceuticals, and its affiliates, business partners, vendors, and other agents (collectively, "Deciphera") health information about me, including information related to my medical condition and treatment, health insurance and coverage claims, and prescription (including fill/refill information) for QINLOCK™ (ripretinib) (my "Information") to (1) enroll me in and provide services under the Deciphera AccessPoint for QINLOCK™ (ripretinib) patient support program (the "Program"); (2) obtain information on my insurance coverage; (3) coordinate prescription fulfillment as indicated by my physician; (4) provide me with adherence reminders and support; and (5) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Deciphera support programs or Deciphera products. Once my Information has been disclosed to Deciphera, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Deciphera will protect my Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise required by law. I understand and agree that the pharmacy that dispenses my QINLOCK™ (ripretinib) may receive payment from Deciphera in exchange for disclosing my Information to Deciphera and providing Program services.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment from my health care providers, my eligibility for health insurance benefits, or my access to Deciphera medications. However, if I do not sign this Authorization, I understand I will not be able to participate in the Program. I understand that this Authorization expires ten years from the date signed below, or as otherwise required by state or local law, unless and until I cancel (take back) this Authorization before then. I may change my mind and cancel this Authorization at any time by calling 1-833-4DACCES (1-833-432-2237) or by notifying Deciphera in writing at PO Box 5490 Louisville, KY 40255. Cancellation of this Authorization will end further uses and disclosures of my Information and my participation in the Program but will not affect any uses or disclosure of my Information made by my health care providers and staff, my pharmacies, and my health insurers based on this Authorization before receipt of the cancellation.

I understand I may request a signed copy of this Authorization.

If signed by a patient representative:

Sign here: ______________________ Date: __________ ______________________ ______________________

Signature of Patient or Patient Representative — Printed Name — Phone Number of Patient Representative

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