GAVRETO™ (pralsetinib) PATIENT SUPPORT PROGRAM ENROLLMENT FORM

To avoid delays, complete the entire form, sign and fax it to YourBlueprint™ at 1-866-370-3082.

The standard services that are initiated with this form include:
- Patient Assistance Program (PAP) (complete section 7A)
- QuickStart (complete section 7B)
- Coverage Interruption (complete section 7C)

◯ Check here if you would like additional support with prior authorizations and/or appeals.

1. PATIENT INFORMATION

Name:_____

Street Address:_____

City:_____ State:_____ ZIP:_____

Date of Birth (MM/DD/YYYY):_____ Sex: ◯ Male ◯ Female

Primary Phone:_____ ◯ Okay to leave voicemail

Alternate Phone:_____ ◯ Okay to leave voicemail

Best Time to Contact: ◯ Morning ◯ Afternoon ◯ Evening

Email Address:_____

Patient Representative / Caregiver:_____

Patient Representative / Caregiver Phone:_____

2. INSURANCE INFORMATION

◯ No Insurance

Please make sure you include your primary prescription insurance. If possible, please also include your medical insurance information.

Primary Prescription Insurer:_____

Phone:_____ Prescription Policy ID:_____

Prescription Group Number:_____ Prescription BIN:_____

Prescription PCN:_____ Subscriber Name:_____

Primary Medical Insurer: _____

Group Number: _____ Policy ID:_____

Secondary Prescription Insurer:_____

Phone:_____ Prescription Policy ID:_____

Prescription Group Number:_____ Prescription BIN:_____

Prescription PCN:_____ Subscriber Name:_____

3. PATIENT FINANCIAL INFORMATION (This information is required to verify eligibility for patient assistance)

Total Number of People Within Household (including applicant):_____

4A. YOURBLUEPRINT ENROLLMENT CONSENT

By signing below, I certify that I have read the YourBlueprint Enrollment Consent on page 2 and I agree to the terms of enrollment.

SIGN HERE X _____ _____
Signature of Patient or Patient Representative — Date

If signed by a Patient Representative

_____ _____
Printed Name — Phone Number of Patient Representative

4B. AUTHORIZATION TO SHARE HEALTH INFORMATION

By signing below, I certify that I have read the Authorization to Share Health Information on page 2 and I authorize the disclosure of my Information to Blueprint Medicines as described.

SIGN HERE X _____ _____
Signature of Patient or Patient Representative — Date

If signed by a Patient Representative

_____ _____
Printed Name — Phone Number of Patient Representative

5. DIAGNOSIS

Primary Diagnosis ICD-10:_____

Is this a Pre-Approval Access Program (PAAP) patient? ◯ Yes ◯ No

If yes, please provide PAAP Patient ID:_____

6. PRESCRIBER INFORMATION

Prescriber Name:_____

Site / Facility Name:_____

Street Address:_____

City:_____ State:_____ ZIP:_____

Office Contact:_____

Phone:_____ Fax:_____

Email:_____

Preferred Method of Communication: ◯ Email ◯ Phone ◯ Fax

NPI #:_____ State License #:_____

7. PRESCRIPTION

The recommended starting dose of GAVRETO is 400 mg QD (four 100 mg capsules).

7A. GAVRETO	**GAVRETO 100 mg capsules** ◯ 400 mg QD by mouth ◯ Other:_____ **Dispense:** 30-day supply	**Refills:**_____
7B. GAVRETO QuickStart *For newly prescribed patients in the event of delay in coverage decision*	**GAVRETO 100 mg capsules** ◯ 400 mg QD by mouth ◯ Other:_____ **Dispense:** 15-day supply	**Refills: 3**
7C. GAVRETO Coverage Interruption *For eligible existing patients during lapse in coverage*	**GAVRETO 100 mg capsules** ◯ 400 mg QD by mouth ◯ Other:_____ **Dispense:** 15-day supply	**Refills: 1**

Directions for use: Take as directed once daily by mouth on an empty stomach, at least 1 hour before and 2 hours after a meal

SIGN HERE _____ _____
Prescriber Signature (no stamps) — Date

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 GAVRETO is medically necessary. I certify that I have obtained my patient's written authorization in accordance with all applicable state and federal law to release the individually identifiable health information included on this form to Blueprint Medicines' YourBlueprint 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 YourBlueprint support services to my patient, including contacting my patient by telephone or mail for these purposes. For specialty pharmacy prescriptions, I authorize YourBlueprint to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Blueprint Medicines product and that I have not received nor will I receive any benefit from Blueprint Medicines for doing so. I will not seek reimbursement from any third-party payer, patient, or other person or entity for any product provided free of charge by YourBlueprint. I attest that I am not on the HHS/OIG list of Excluded Individuals.

Special Note: New York prescriber, please use an original New York State prescription form. The prescriber is to comply with the prescriber's state-specific prescription requirements.

8. PHARMACY PREFERENCE

◯ Biologics ◯ PANTHERx Rare Pharmacy ◯ Medically Integrated Dispenser (MID)

Prescription Already Sent: ◯ Yes ◯ No

If you selected MID, please complete the information below:

MID Name:_____ MID Phone:_____

MID NPI/DEA/HIN #:_____ MID Fax:_____

Phone: 1-888-BLUPRNT (1-888-258-7768) | Fax: 1-866-370-3082 | Monday-Friday 8 AM-8 PM ET | www.YourBlueprint.com

FOR CO-PAY ENROLLMENT, PLEASE VISIT PORTAL.TRIALCARD.COM/YOURBLUEPRINT

GAVRETO™ (pralsetinib) Enrollment Consent and Privacy Authorization

YOURBLUEPRINT™ ENROLLMENT CONSENT

Please read the following, and if you agree, sign section 4A of the Enrollment Form.

By signing below, I am enrolling in the YourBlueprint patient support program (the "Program"). I authorize Blueprint Medicines Corporation and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Blueprint Medicine Corporation, "Blueprint Medicines") 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 Co-Pay 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 Blueprint Medicines and its business partners may use and share with each other and with my healthcare providers, pharmacies, and health insurance plans, information about me in connection with providing services to me under the Program, administering the Program, or as otherwise required for Blueprint Medicines to meet its legal obligations. I authorize Blueprint Medicines to contact me by mail, telephone, and email in connection with the Program services and also with information about Blueprint Medicines' products, promotions, services, or research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize Blueprint Medicines to de-identify my information and use it in performing research, education, business analytics, and marketing studies or for other commercial purposes.

I understand I do not have to enroll in the Program and that I can still receive my medication as prescribed by my physician. I understand that I may at any time opt out of individual services offered by the Program or opt out of the Program entirely by notifying a Program representative by calling 1-888-BLUPRNT (1-888-258-7768) or by writing to YourBlueprint at PO Box 15590, Pittsburgh, PA 15244. I understand that the Program may be changed or discontinued in whole or in part by Blueprint Medicines at any time.

AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read this page carefully, and if you agree, sign and date where indicated in section 4B of the Enrollment Form. You may keep a copy of this form for your records.

I authorize my healthcare providers and staff, my pharmacies, and my health insurers to use and to disclose to Blueprint Medicines and its affiliates, business partners, vendors, and other agents (collectively, "Blueprint Medicines") 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 my medication (my "Information") for the purpose of enrolling me in, providing services under, and conducting quality assurance and other administrative activities in furtherance of, the YourBlueprint patient support program (the "Program"). Once my Information has been disclosed to Blueprint Medicines, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Blueprint Medicines will protect my Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise required or permitted by law. I understand that the pharmacy that dispenses my medication may receive payment from Blueprint Medicines in exchange for my Information and/or for providing support services to me in connection with the Program.

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 healthcare providers, my eligibility for health insurance benefits, or my access to Blueprint Medicines' 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 earlier as may be 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 1-888-BLUPRNT (1-888-258-7768) or by notifying Blueprint Medicines in writing at PO Box 15590, Pittsburgh, PA 15244. 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 healthcare 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.

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