PATIENT SUPPORT PROGRAM CONSENT AND HIPAA AUTHORIZATION

Please fill out this form completely, sign and send back both pages via one of the following methods:

- Fax this page to 1-866-370-3082 *OR*
- Scan / photograph and email this form to info@yourblueprint.com *OR*
- Mail this form to YourBlueprint™, PO Box 15590, Pittsburgh, PA 15244

For additional assistance, call 1-888-BLUPRNT (1-888-258-7768), Monday-Friday, 8 AM-8 PM Eastern Time (ET)

PATIENT INFORMATION

Patient Name (First, MI, Last):_____ Date of Birth (MM/DD/YYYY):_____

Street Address:_____

City:_____ State:_____ ZIP:_____ Sex: ◯ Male ◯ Female

Email Address:_____

Primary Phone:_____ ◯ Okay to leave voicemail Best Time to Contact: ◯ Morning ◯ Afternoon ◯ Evening

Alternate Phone:_____ ◯ Okay to leave voicemail Best Time to Contact: ◯ Morning ◯ Afternoon ◯ Evening

Patient Representative / Caregiver:_____

Patient Representative / Caregiver Phone:_____

PHYSICIAN INFORMATION

Prescriber Name (First, MI, Last):_____

Site / Facility Name:_____

State:_____

YOURBLUEPRINT ENROLLMENT CONSENT

Please read the following, and if you agree, sign below.

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.

By signing below, I certify that I have read the YourBlueprint Enrollment Consent 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

Privacy Authorization and Enrollment Consent

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AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read this page carefully, and if you agree, sign the Authorization to Share Health Information agreement below. 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.

By signing below, I certify that I have read the Authorization to Share Health Information 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

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