AYVAKIT®
avapritinib | tablets

Access and Reimbursement Guide for Healthcare Providers

Information on Distribution, Patient Support, Coverage, and Access

Enroll your patients at time of prescription
to support the patient experience and access to programs

www.YourBlueprint.com

Blueprint Medicines is pleased to provide this information to help you and your office staff navigate coverage and access for AYVAKIT® (avapritinib). It is not intended to supersede any individual payer guidance and/or processes. Please be sure to check directly with each patient's insurance for any specific requirements needed to help obtain coverage and access. This document is presented for informational purposes only and does not guarantee reimbursement.

Table of Contents

PRODUCT INFORMATION

Indications & Important Safety Information 3

Dosing & Administration 4

Ordering Information 6

PATIENT SUPPORT WITH YOURBLUEPRINT®

Overview of Support Services Provided for Eligible Patients by Blueprint Medicines 7

NAVIGATING THE APPROVAL PROCESS

Benefits Verification 13

Prior Authorization (PA) Documentation Checklist 14

DENIALS & APPEALS

Common Reasons for Coverage Denials 15

AYVAKIT Appeals Request Checklist 16

Sample Coverage Determination Request Letters 17

DIAGNOSTIC TESTING & CODING

Advanced Systemic Mastocytosis (AdvSM) and Indolent Systemic Mastocytosis (ISM) 18

PDGFRA Exon 18 Mutation-Positive Unresectable or Metastatic GIST 20

Product Information

INDICATIONS

AYVAKIT® (avapritinib) is indicated for the treatment of adult patients with:

Unresectable or Metastatic Gastrointestinal Stromal Tumor (GIST)

harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations

Advanced SM (AdvSM)

including patients with aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL)

Limitations of Use: AYVAKIT is not recommended for the treatment of patients with AdvSM with platelet counts of <50 X 10^9/L

Indolent Systematic Mastocytosis (ISM)

Limitations of Use: AYVAKIT is not recommended for patients with platelet counts of <50 x 10^9/L

IMPORTANT SAFETY INFORMATION

There are no contraindications for AYVAKIT.

Intracranial Hemorrhage—Serious intracranial hemorrhage (ICH) may occur with AYVAKIT treatment; fatal events occurred in <1% of patients. Overall, ICH (eg, subdural hematoma, ICH, and cerebral hemorrhage) occurred in 2.9% of 749 patients who received AYVAKIT in clinical trials. In GIST patients, ICH occurred in 3 of 267 patients (1.1%) and two (0.7%) of the events were Grade ≥3 and resulted in discontinuation. In AdvSM patients who received AYVAKIT at 200 mg daily, ICH occurred in 2 of 75 patients (2.7%) who had platelet counts ≥50 x 10^9/L prior to initiation of therapy and in 3 of 80 patients (3.8%) regardless of platelet counts. In ISM patients, no events of ICH occurred in the 246 patients who received any dose of AYVAKIT in the PIONEER study.

Monitor patients closely for risk factors of ICH which may include history of vascular aneurysm, intracranial hemorrhage or cerebrovascular accident within the prior year, concomitant use of anticoagulant drugs, or thrombocytopenia.

Symptoms of intracranial hemorrhage may include headache, nausea, vomiting, vision changes, or altered mental status. Advise patients to seek immediate medical attention for signs or symptoms of ICH.

Permanently discontinue AYVAKIT if ICH of any grade occurs. In AdvSM patients, a platelet count must be performed prior to initiating therapy. AYVAKIT is not recommended in AdvSM patients with platelet counts <50 x 10^9/L. Following treatment initiation, platelet counts must be performed every 2 weeks for the first 8 weeks. After 8 weeks of treatment, monitor platelet counts every 2 weeks or as clinically indicated based on platelet counts. Manage platelet counts of <50 x 10^9/L by treatment interruption or dose reduction.

Cognitive Effects—Cognitive adverse reactions can occur in patients receiving AYVAKIT and occurred in 33% of 995 patients overall in patients who received AYVAKIT in clinical trials including: 41% of 601 GIST patients (5% were Grade ≥3), 28% of 148 AdvSM patients (3% were Grade ≥3), and 7.8% of patients with ISM who received AYVAKIT + best supportive care (BSC) versus 7.0% of patients who received placebo + BSC (<1% were Grade 3). Depending on the severity and indication, withhold AYVAKIT and then resume at same dose or at a reduced dose upon improvement, or permanently discontinue.

Photosensitivity—AYVAKIT may cause photosensitivity reactions. In all patients treated with AYVAKIT in clinical trials (n=1049), photosensitivity reactions occurred in 2.5% of patients. Advise patients to limit direct ultraviolet exposure during treatment with AYVAKIT and for one week after discontinuation of treatment.

Embryo-Fetal Toxicity—AYVAKIT can cause fetal harm when administered to a pregnant woman. Advise pregnant women of the potential risk to a fetus. Advise females and males of reproductive potential to use an effective method of contraception during treatment with AYVAKIT and for 6 weeks after the final dose of AYVAKIT. Advise women not to breastfeed during treatment with AYVAKIT and for 2 weeks after the final dose.

Please see additional Important Safety Information on page 4 and click here to see the full Prescribing Information for AYVAKIT.

IMPORTANT SAFETY INFORMATION (CONT.)

Adverse Reactions—The most common adverse reactions (≥20%) in patients with unresectable or metastatic GIST were edema, nausea, fatigue/asthenia, cognitive impairment, vomiting, decreased appetite, diarrhea, increased lacrimation, abdominal pain, constipation, rash, dizziness, and hair color changes.

The most common adverse reactions (≥20%) in patients with AdvSM were edema, diarrhea, nausea, and fatigue/asthenia.

The most common adverse reactions (≥10%) in patients with ISM were eye edema, dizziness, peripheral edema, and flushing.

Drug Interactions—Avoid coadministration of AYVAKIT® with strong or moderate CYP3A inhibitors. If coadministration with a moderate CYP3A inhibitor cannot be avoided in patients with GIST or AdvSM, reduce dose of AYVAKIT. Avoid coadministration of AYVAKIT with strong or moderate CYP3A inducers.

To report suspected adverse reactions, contact Blueprint Medicines Corporation at 1-888-258-7768 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DOSING & ADMINISTRATION

Recommended Administration (Section 2.1)*

Administer AYVAKIT® orally on an empty stomach, at least 1 hour before or 2 hours after a meal.

Do not make up for a missed dose within 8 hours of the next scheduled dose.

Do not repeat dose if vomiting occurs after AYVAKIT but continue with the next scheduled dose.

GIST Harboring PDGFRA Exon 18 Mutations (Section 2.2)*

Select patients for treatment with AYVAKIT based on the presence of a PDGFRA exon 18 mutation. An FDA-approved test for the detection of exon 18 mutations is not currently available.

The recommended dosage of AYVAKIT is 300 mg orally once daily in patients with GIST. Continue treatment until disease progression or unacceptable toxicity.

Advanced Systemic Mastocytosis (Section 2.3)*

The recommended dosage of AYVAKIT is 200 mg orally once daily in adult patients with AdvSM. Continue treatment until disease progression or unacceptable toxicity.

Indolent Systemic Mastocytosis (Section 2.4)*

The recommended dosage of AYVAKIT is 25 mg orally once daily in patients with ISM.

Dosage Modifications for Adverse Reactions (Section 2.5)*

The recommended dosage reductions and modifications for adverse reactions are provided in the tables below.

Recommended Dosage Reductions for AYVAKIT for Adverse Reactions

Dose Reduction Level	Dosage in patients with GIST†	Dosage in patients with AdvSM‡
First dose reduction	200 mg once daily	100 mg once daily
Second dose reduction	100 mg once daily	50 mg once daily
Third dose reduction	–	25 mg once daily

†Permanently discontinue AYVAKIT in patients with GIST who are unable to tolerate a dose of 100 mg once daily.
‡Permanently discontinue AYVAKIT in patients with AdvSM who are unable to tolerate a dose of 25 mg once daily.

*AYVAKIT® (avapritinib) Prescribing Information. Blueprint Medicines Corporation; Cambridge, MA.

Recommended Dosage Modifications for AYVAKIT® for Adverse Reactions

Adverse Reaction	Severity*	Dosage Modification
Patients with GIST or AdvSM		
Intracranial Hemorrhage	Any grade	Permanently discontinue AYVAKIT.
Cognitive Effects	Grade 1	Continue AYVAKIT at same dose or reduced dose or withhold until improvement to baseline or resolution. Resume at same dose or reduced dose.
	Grade 2 or Grade 3	Withhold AYVAKIT until improvement to baseline, Grade 1, or resolution. Resume at same dose or reduced dose.
	Grade 4	Permanently discontinue AYVAKIT.
Other	Grade 3 or Grade 4	Withhold AYVAKIT until improvement to less than or equal to Grade 2. Resume at same dose or reduced dose, as clinically appropriate.
Patients with AdvSM		
Thrombocytopenia	$<50 \times 10^9$/L	Interrupt AYVAKIT until platelet count is $\geq 50 \times 10^9$/L, then resume at reduced dose (per Table 1). If platelet counts do not recover above 50×10^9/L, consider platelet support.

*Severity as defined by the National Cancer Institute Common Terminology Criteria for Adverse Events version 5.0.

Concomitant Use of Strong and Moderate CYP3A Inhibitors (Section 2.6)†

Avoid concomitant use of AYVAKIT with strong or moderate CYP3A inhibitors. If concomitant use with a moderate CYP3A inhibitor cannot be avoided, the starting dosage of AYVAKIT is as follows:

- GIST: 100 mg orally once daily
- AdvSM: 50 mg orally once daily

For ISM, avoid concomitant use of AYVAKIT with strong or moderate CYP3A inhibitors.

Dosage Modifications for Severe Hepatic Impairment (Section 2.7)†

A modified starting dosage of AYVAKIT is recommended for patients with severe hepatic impairment (Child-Pugh Class C):

- GIST: 200 mg orally once daily
- AdvSM: 100 mg orally once daily
- ISM: 25 mg orally every other day

†AYVAKIT® (avapritinib) Prescribing Information. Blueprint Medicines Corporation; Cambridge, MA.

ORDERING INFORMATION

AYVAKIT® is available through a select network of specialty pharmacies and specialty distributors.

Specialty Pharmacy Provider Network

To prescribe AYVAKIT, please complete the YourBlueprint® Enrollment Form and fax it to 1-866-370-3082, or send your patient's prescription to one of the authorized specialty pharmacies listed below.

Biologics
Phone: 1-800-850-4306
Fax: 1-800-823-4506
ePrescribe: Biologics or
NPI# 1487640314

Onco360
Phone: 1-877-662-6633
Fax: 1-877-662-6355
ePrescribe: Oncomed DBA Onco360 or
NPI# 1679618151

PANTHERx Rare Pharmacy
Phone: 1-833-918-2015
Fax: 1-855-246-3986
ePrescribe: PANTHERx Rare Pharmacy or
NPI #1659762524

Specialty Distribution Network

The following specialty distributors are authorized to drop-ship AYVAKIT to qualified accounts.

Physician Dispensing Offices

Cardinal Health Specialty Distribution
Phone: 1-855-855-0708
Email: GMB-SPD-Specialty@cardinalhealth.com

McKesson Specialty Health
Phone: 1-855-477-9800
Email: MSH.CustomerCare-MSPL@mckesson.com

Oncology Supply
Phone: 1-800-633-7555
Email: service@oncologysupply.com

Institutions/Hospitals

ASD Healthcare
Phone: 1-800-746-6273
Email: service@asdhealthcare.com

Cardinal Health Specialty Distribution
Phone: 1-855-855-0708
Email: GMB-SPD-Specialty@cardinalhealth.com

McKesson Plasma and Biologics
Phone: 1-877-625-2566
Email: MPBOrders@mckesson.com

Blueprint Medicines does not endorse the use of any particular specialty pharmacy or specialty distributor listed above and makes no representation or guarantee of services or coverage of any product. This list is current as of 3/2023 and may be updated from time to time.

AYVAKIT Product Information

AYVAKIT tablets are supplied in 5 dosage strengths:

Dosage Strength	300 mg	200 mg	100 mg	50 mg	25 mg
NDC Codes	10-digit code: **72064-130-30** 11-digit code: **72064-0130-30**	10-digit code: **72064-120-30** 11-digit code: **72064-0120-30**	10-digit code: **72064-110-30** 11-digit code: **72064-0110-30**	10-digit code: **72064-150-30** 11-digit code: **72064-0150-30**	10-digit code: **72064-125-30** 11-digit code: **72064-0125-30**
Description	300 mg, capsule-shaped, white film-coated tablet, printed with blue ink "BLU" on one side and "300" on the other side; available in bottles of 30 tablets.	200 mg, capsule-shaped, white film-coated tablet, printed with blue ink "BLU" on one side and "200" on the other side; available in bottles of 30 tablets.	100 mg, round, white film-coated tablet, printed with blue ink "BLU" on one side and "100" on the other side; available in bottles of 30 tablets.	50 mg, round, white film-coated tablet with debossed text. One side reads "BLU" and the other side reads "50"; available in bottles of 30 tablets.	25 mg, round, white film-coated tablet with debossed text. One side reads "BLU" and the other side reads "25"; available in bottles of 30 tablets.

Please note that splitting or breaking up individual pills is not advised.

The blue zero converts the 10-digit NDC code to the 11-digit NDC code. Some payers may require each NDC to be listed on the claim. Payer requirements regarding the use of NDCs may vary. Electronic data exchange generally requires use of the 11-digit NDC.

Storage: Store AYVAKIT at controlled room temperature 20 °C to 25 °C (68 °F to 77 °F); excursions are permitted between 15 °C and 30 °C (59 °F and 86 °F) [see USP Controlled Room Temperature].

Patient Support with YourBlueprint®

Enroll your patients at time of prescription
to support the patient experience and access to programs

YourBlueprint is a patient support program designed with your patients in mind. YourBlueprint assists eligible patients throughout many aspects of treatment by providing a variety of support along the treatment journey.

Resources to assist your patients with financial needs

CO-PAY ASSISTANCE
Eligible patients with commercial insurance may be able to reduce their out-of-pocket costs (co-pay, co-insurance, or deductible) to as little as $0 per fill up to an annual maximum of $25,000. Please contact YourBlueprint to learn more about eligibility

PATIENT ASSISTANCE PROGRAM (PAP)
Eligible patients with no insurance, limited coverage, or unaffordable out-of-pocket costs may be able to receive their medication at no cost

Resources to help your patients rapidly access treatment once prescribed and while coverage is being confirmed

QUICKSTART
A no-cost, limited supply in the event of an insurance coverage delay

REIMBURSEMENT SUPPORT AND RESOURCES
Benefits verification and resources related to prior authorizations, appeals, and formulary exceptions provided by Blueprint Medicines

Resources to ensure continued access

COVERAGE INTERRUPTION
A no-cost, limited supply in the event of a patient experiencing a temporary lapse in coverage while on therapy

DOSE EXCHANGE
Allows patients whose healthcare provider (HCP) recommends a dose modification to exchange their remaining medication for the new dose at no cost

Resource to support your patients once treatment has begun

PSYCHOSOCIAL PATIENT SUPPORT CALLS
For those who opt in to the program

Learn more about accessing each of the programs in the following pages

If you are interested in learning more about dispensing a Blueprint Medicines' therapy, visit **YourBlueprint.com/HCP** and go to the **"How to Order"** section

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

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

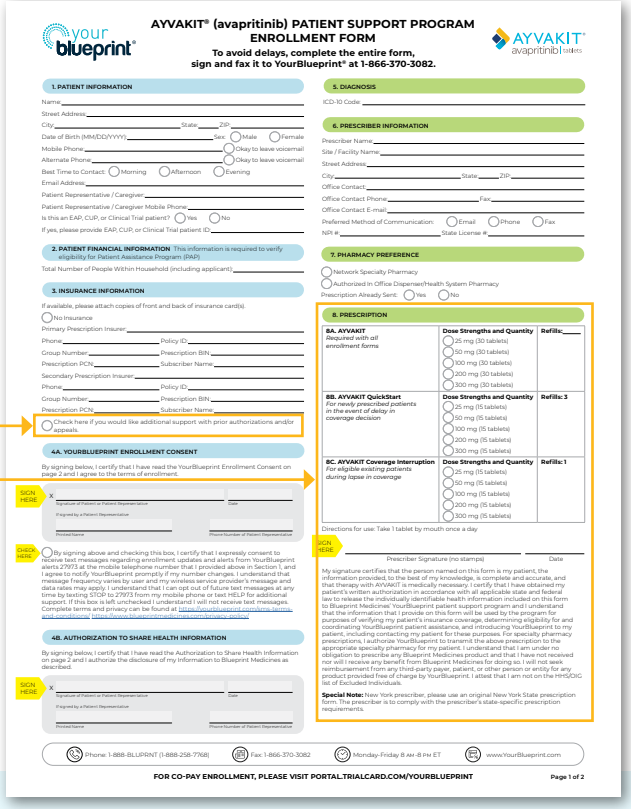
To access support services for your patient, fill out the YourBlueprint® enrollment form

- Be sure to completely fill in the **enrollment form**, including patient signatures and HCP signature. If the patient is unable to sign in person, the patient can submit their signature through DocuSign **here**
- Submitting the enrollment form to YourBlueprint at the time of prescribing will enable the YourBlueprint team to proactively support your patient's access needs

Select for reimbursement support, including benefits summary, prior authorization, appeals and formulary exceptions support

Select any or all medication access resources within prescription section 8. If all portions of the prescription section are submitted upon initial enrollment, patients can more rapidly access those resources if needed in the future without having to reach back out to your office or pharmacy – Patient Assistance Program (PAP) (8A), QuickStart (8B) and Coverage Interruption (8C)

Upon receipt of enrollment form, YourBlueprint will reach out to your office to review next steps.



AYVAKIT® (avapritinib) PATIENT SUPPORT PROGRAM ENROLLMENT FORM

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

1. PATIENT INFORMATION
2. PATIENT FINANCIAL INFORMATION This information is required to verify eligibility for Patient Assistance Program (PAP)
3. INSURANCE INFORMATION
4A. YOURBLUEPRINT ENROLLMENT CONSENT
4B. AUTHORIZATION TO SHARE HEALTH INFORMATION
5. DIAGNOSIS
6. PRESCRIBER INFORMATION
7. PHARMACY PREFERENCE
8. PRESCRIPTION

8A. AYVAKIT *Required with all enrollment forms*	Dose Strengths and Quantity: 25 mg (30 tablets); 50 mg (30 tablets); 100 mg (30 tablets); 200 mg (30 tablets); 300 mg (30 tablets)	Refills:___
8B. AYVAKIT QuickStart *For newly prescribed patients in the event of delay in coverage decision*	Dose Strengths and Quantity: 25 mg (15 tablets); 50 mg (15 tablets); 100 mg (15 tablets); 200 mg (15 tablets); 300 mg (15 tablets)	Refills: 3
8C. AYVAKIT Coverage Interruption *For eligible existing patients during lapse in coverage*	Dose Strengths and Quantity: 25 mg (15 tablets); 50 mg (15 tablets); 100 mg (15 tablets); 200 mg (15 tablets); 300 mg (15 tablets)	Refills: 1

Directions for use: Take 1 tablet by mouth once a day

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

Page 1 of 2

SUBMIT THE ENROLLMENT FORM TO YOURBLUEPRINT BY:

Fax: **1-866-370-3082**

OR

Email: **info@yourblueprint.com**

For patients unable to sign in person:

Select E-consent and sign via DocuSign*

*DocuSign can be completed on computer, mobile device, or tablet

OR

Download Consent Form and return via:

- **Email to** info@yourblueprint.com - or -
- **Mail to** YourBlueprint, PO Box 15590, Pittsburgh, PA 15244

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

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

Supporting Access to Treatment

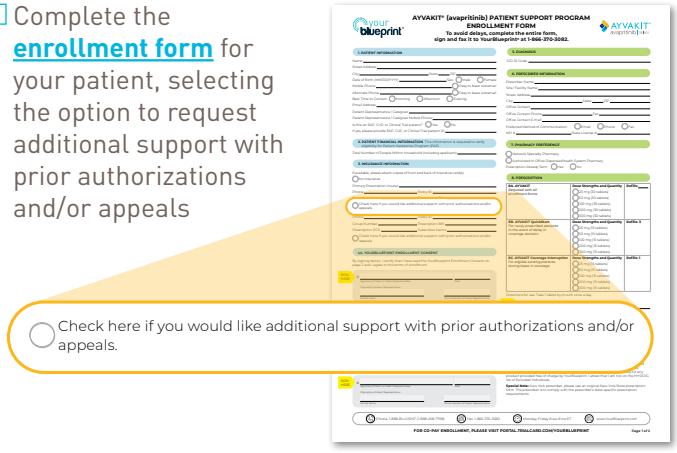
REIMBURSEMENT RESOURCES

What is it?

YourBlueprint® will work with the patient's insurance plan to determine the path to access and communicate with you the requirements for coverage, including the correct form to submit, the supporting documentation to provide, and where to send it

What do we need from you?

- ☐ Complete the **enrollment form** for your patient, selecting the option to request additional support with prior authorizations and/or appeals



- ☐ Ensure patient's insurance information is completed on the form

QUICKSTART

What is it?

Should the patient's coverage determination be delayed more than 5 business days from the date your office submits the PA to the payer, YourBlueprint will provide eligible patients with up to a 60-day limited supply of no-cost medication pending a final coverage determination or, if needed, a PAP eligibility determination may be made

What do we need from you?

- ☐ Complete the **enrollment form** for your patient, selecting the QuickStart prescription in section 8B of the enrollment form
- ☐ Provide YourBlueprint with the PA submission date with the enrollment form

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

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

Financial Needs

CO-PAY ASSISTANCE

What is it?

For eligible patients enrolled in co-pay assistance who have commercial insurance, YourBlueprint® will assist with their out-of-pocket expenses, and patients can pay as little as $0 for their Blueprint Medicines therapy up to an annual maximum of $25,000. Please contact YourBlueprint to learn more about eligibility

What do we need from you?

- ☐ Enroll your patient via the online portal **here**
- ☐ Once enrolled, adjudication information will be assigned to your patient and you can adjudicate the claim using your pharmacy system

Your Medically Integrated Dispensing (MID) pharmacy must be contracted with our co-pay processor to adjudicate claims. Visit www.YourBlueprint.com for a comprehensive guide on contracting with our co-pay processor, or contact your Blueprint Medicines Area Business Manager.

PATIENT ASSISTANCE PROGRAM (PAP)

What is it?

Patients with no insurance, no coverage for AYVAKIT®, or high out-of-pocket costs, including Medicare Part D, for their Blueprint Medicines therapy may be eligible to receive their therapy at no cost through our non-commercial dispensing pharmacy

What do we need from you?

- ☐ Complete the **enrollment form** for your patient, selecting the prescription in section 3 and 8A of the enrollment form
- ☐ If patient has insurance but no coverage for their therapy, provide YourBlueprint the prior authorization and two (2) subsequent appeal denials with the enrollment form

PAP Financial Eligibility Criteria

For patients with high out-of-pocket costs

$150,000 for a household of 4, as determined by electronic verification*

For Medicare Part D, annual out-of-pocket cost for medication must be in excess of 4% of annual income. This criterion does not apply for certain low-income Medicare Part D beneficiaries.

For non-Medicare Part D, annual out-of-pocket costs for medication must exceed 20% of annual income.

*If unable to determine income via eVerify, patient will need to submit 1040 or 1040-SR to YourBlueprint. Asset information not collected.

Household Size†	1	2	3	4
Household Income	$75,000	$100,000	$125,000	$150,000

†Add $25,000 for every additional person over the first four.

For patients with no insurance or no coverage for AYVAKIT:

During the then-current calendar year, patient's household must have spent or must have evidence of anticipated out-of-pocket financial liability for AYVAKIT of at least 20% of their estimated annual household income.

Eligibility criteria as of May 2023. Program is subject to modification. Please contact YourBlueprint for current eligibility criteria.

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

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

Continued Access to Treatment While on Therapy

COVERAGE INTERRUPTION

What is it?

Should the patient experience a temporary lapse in coverage for their therapy, YourBlueprint® will provide eligible patients with a limited supply of no-cost medication. Examples of eligible coverage lapse could be PA expiration or job transition

What do we need from you?

☐ Complete the **enrollment form** for your patient, selecting the Coverage Interruption prescription in section 8C of the enrollment form

DOSE EXCHANGE

What is it?

Should the patient experience a dose modification while on AYVAKIT®, the patient may exchange their remaining medication for the new prescribed dose at no cost to them

What do we need from you?

☐ Complete the **Dose Exchange Form** for your patient and submit to the YourBlueprint non-commercial pharmacy for dispensing

Psychosocial Patient Support Calls

YourBlueprint enrolled patients are given the option to participate in psychosocial support phone calls. These calls are intended to support patients through conversation topics that are focused on various aspects of therapy, such as: how to prepare for upcoming doctors visits, nutrition, workplace accommodations, or talking with their family about diagnosis. The call schedule is dependent on the patient's preference.

All programs are subject to eligibility criteria. For more information, please connect with YourBlueprint for details.

Phone: 1-888-BLUPRNT (1-888-258-7768)

Fax: 1-866-370-3082

info@yourblueprint.com

Monday-Friday 8 AM-8 PM ET

www.YourBlueprint.com

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

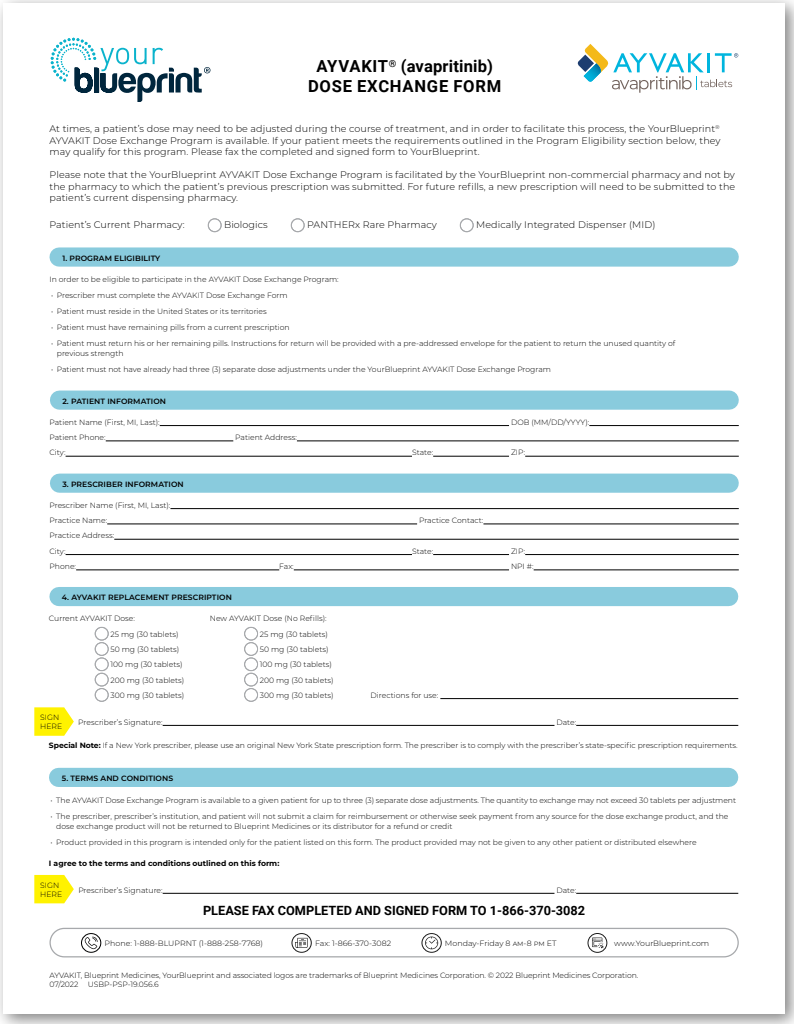
DOSE EXCHANGE PROGRAM

At times, a patient's dose may need to be adjusted during the course of treatment, and in order to facilitate this process, the YourBlueprint® Dose Exchange Program is available. If your patient meets the requirements outlined in the Program Eligibility section below, they may qualify for this program. Please fax the completed and signed form to YourBlueprint.

Please note that the YourBlueprint Dose Exchange Program is facilitated by the YourBlueprint non-commercial pharmacy and not by the pharmacy to which the patient's previous prescription was submitted. For future refills, a new prescription will need to be submitted to the patient's current dispensing pharmacy.

In order to be eligible to participate in the Dose Exchange Program:

- Prescriber must complete the **Dose Exchange Form**
- Patient must reside in the United States or its territories
- Patient must have remaining pills from a current prescription
- Patient must return his or her remaining pills. Instructions for return will be provided with a pre-addressed envelope for the patient to return the unused quantity of previous strength
- Patient must not have already had 2 separate dose adjustments under the YourBlueprint Dose Exchange Program



AYVAKIT® (avapritinib)
DOSE EXCHANGE FORM

AYVAKIT® avapritinib | tablets

At times, a patient's dose may need to be adjusted during the course of treatment, and in order to facilitate this process, the YourBlueprint® AYVAKIT Dose Exchange Program is available. If your patient meets the requirements outlined in the Program Eligibility section below, they may qualify for this program. Please fax the completed and signed form to YourBlueprint.

Please note that the YourBlueprint AYVAKIT Dose Exchange Program is facilitated by the YourBlueprint non-commercial pharmacy and not by the pharmacy to which the patient's previous prescription was submitted. For future refills, a new prescription will need to be submitted to the patient's current dispensing pharmacy.

Patient's Current Pharmacy: ◯ Biologics ◯ PANTHERx Rare Pharmacy ◯ Medically Integrated Dispenser (MID)

1. PROGRAM ELIGIBILITY

In order to be eligible to participate in the AYVAKIT Dose Exchange Program:

- Prescriber must complete the AYVAKIT Dose Exchange Form
- Patient must reside in the United States or its territories
- Patient must have remaining pills from a current prescription
- Patient must return his or her remaining pills. Instructions for return will be provided with a pre-addressed envelope for the patient to return the unused quantity of previous strength
- Patient must not have already had three (3) separate dose adjustments under the YourBlueprint AYVAKIT Dose Exchange Program

2. PATIENT INFORMATION

Patient Name (First, MI, Last):_____ DOB (MM/DD/YYYY):_____
Patient Phone:_____ Patient Address:_____
City:_____ State:_____ ZIP:_____

3. PRESCRIBER INFORMATION

Prescriber Name (First, MI, Last):_____
Practice Name:_____ Practice Contact:_____
Practice Address:_____
City:_____ State:_____ ZIP:_____
Phone:_____ Fax:_____ NPI #:_____

4. AYVAKIT REPLACEMENT PRESCRIPTION

Current AYVAKIT Dose:
◯ 25 mg (30 tablets)
◯ 50 mg (30 tablets)
◯ 100 mg (30 tablets)
◯ 200 mg (30 tablets)
◯ 300 mg (30 tablets)

New AYVAKIT Dose (No Refills):
◯ 25 mg (30 tablets)
◯ 50 mg (30 tablets)
◯ 100 mg (30 tablets)
◯ 200 mg (30 tablets)
◯ 300 mg (30 tablets)

Directions for use:_____

SIGN HERE Prescriber's Signature:_____ Date:_____

Special Note: If a 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.

5. TERMS AND CONDITIONS

- The AYVAKIT Dose Exchange Program is available to a given patient for up to three (3) separate dose adjustments. The quantity to exchange may not exceed 30 tablets per adjustment
- The prescriber, prescriber's institution, and patient will not submit a claim for reimbursement or otherwise seek payment from any source for the dose exchange product, and the dose exchange product will not be returned to Blueprint Medicines or its distributor for a refund or credit
- Product provided in this program is intended only for the patient listed on this form. The product provided may not be given to any other patient or distributed elsewhere

I agree to the terms and conditions outlined on this form:

SIGN HERE Prescriber's Signature:_____ Date:_____

PLEASE FAX COMPLETED AND SIGNED FORM TO 1-866-370-3082

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

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

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

Navigating the Approval Process

YourBlueprint® can help with questions you may have about the approval process, including prior authorization (PA) and navigating coverage denials for AYVAKIT®.

Contact YourBlueprint at **1-888-BLUPRNT** (1-888-258-7768) for assistance.

Typical Approval Process

BENEFITS VERIFICATION

YourBlueprint can help conduct benefits verifications

YourBlueprint can conduct a benefits verification to determine a patient's health insurance coverage and out-of-pocket costs. After verifying coverage, YourBlueprint will provide a summary of benefits to you over the phone as well as by fax. The patient can call to review the summary of benefits verbally, and upon request, receive a copy by mail.

Prior authorization requirement? YourBlueprint can help

YourBlueprint can support your patient through the process of managing a prior authorization requirement. Here is what you can expect:

First, we will coordinate with your patient's insurer to gather the prior authorization requirements, including the payer-specific documents → We will then contact you to help guide you through the submission process and provide you the necessary documents for you to complete, including a documentation checklist → After your office submits the prior authorization request, upon your request, we can track the progress and communicate the status of a prior authorization to you

PRIOR AUTHORIZATION (PA) DOCUMENTATION CHECKLIST

Approval processes and prior authorization requirements vary by payer. This checklist is provided to help navigate the prior authorization process for AYVAKIT®.

The information shown below may be required by payers to obtain a prior authorization, however, individual payers may have their own forms or requirements.

In the case of a prior authorization denial or need for a formulary exception request, detailed information about those processes and documentation requirements are found in the Denials & Appeals section of this guide.

This checklist is provided to help you navigate the approval process in the likely event that AYVAKIT requires a prior authorization.

Complete and submit the prior authorization form as required by the payer that may include:

- ☐ Patient's name
- ☐ Patient's insurance company and policy number
- ☐ Patient's date of birth
- ☐ Patient's diagnosis / ICD-10 code(s)
- ☐ Provider details, specialty, contact information, and NPI number
- ☐ AYVAKIT NDC, dosage, route of administration, and estimated duration of treatment

If not part of the prior authorization form, it may be helpful to include the following:

- ☐ Full Prescribing Information
- ☐ Information related to the treatment decision
- ☐ Peer-reviewed journal articles
- ☐ Clinical practice guidelines

Include a comprehensive letter of medical necessity written on your own letterhead that includes the following (see sample letter on page 17):

- ☐ Rationale for treatment with AYVAKIT
- ☐ Patient-specific medical history related to the ICD-10 code
- ☐ Patient's diagnostic test results (e.g., PDGFRA exon 18 for GIST, AdvSM diagnostic criteria, ISM diagnostic criteria), as required by individual payer
- ☐ Previous treatments (names), duration, and response or reason for discontinuation
- ☐ Patient's current symptoms or condition

If a prior authorization has been denied, see page 16 for an appeals checklist or available for download at www.YourBlueprint.com/HCP

Denials & Appeals

COMMON REASONS FOR COVERAGE DENIALS

Here are some common reasons for coverage denials that may be resolvable through the appeals or formulary exception request processes.

New Drug
Not yet reviewed by payer and considered non-formulary

Missing Information
Coverage request is missing information or there was a data error

Prior Authorization Required
PA not submitted with coverage request

Insurance Information
Patient's insurance changed or coverage has lapsed

If a request for coverage of AYVAKIT® is denied, it may be resolvable through the standard appeals process, which consists of three levels.

1. **1st Level Appeal**
   Contact payer to request a consideration of the denial. This may include a "peer-to-peer" discussion with the medical reviewer
2. **2nd Level Appeal**
   At this step, the appeal is typically reviewed by a medical director of the plan to determine whether the request should be accepted within the coverage guidelines
3. **Independent External Review**
   If attempts to appeal a coverage decision have not been successful, an external review can be conducted by an independent third party to make a binding decision

Patients may also assist with the appeals process.

If a request for coverage of AYVAKIT is denied, patients can contact their employer's benefits administrator or their health plan for additional information on how to appeal the payer's decision or to request an external review.

In some cases, it may be necessary to submit a formulary exception request to the payer. Common processes for commercial payers and Medicare Part D are described in this guide.

AYVAKIT® APPEALS REQUEST CHECKLIST

If the patient's health plan has not established coverage or has denied coverage for AYVAKIT, it may be necessary to submit an appeal or a formulary exception request.

The information below includes general information, however, individual payers may have their own forms or documentation requirements.

Review the denial letter or notification received

Understand why coverage for AYVAKIT was denied and consider the following common questions:

- ☐ Has coverage for AYVAKIT been established for patient's condition / diagnosis?
- ☐ Did the prior authorization include all information as required by the payer or was information missing? Note: some payers may require confirmation of the AdvSM diagnosis with associated documentation (e.g., provider attestation, bone marrow biopsy results)
- ☐ Was the insurance information correct?
- ☐ Did the patient's insurance change or coverage lapse?

Initiate the appeals process

Understand the payer's specific process or requirements:

- ☐ Use payer-specific forms, if available
- ☐ Follow payer's instructions on the appeals submission process and filing timelines
- ☐ Include all required documentation such as
  - Letter of medical necessity
  - Biomarker status
  - Treatment rationale

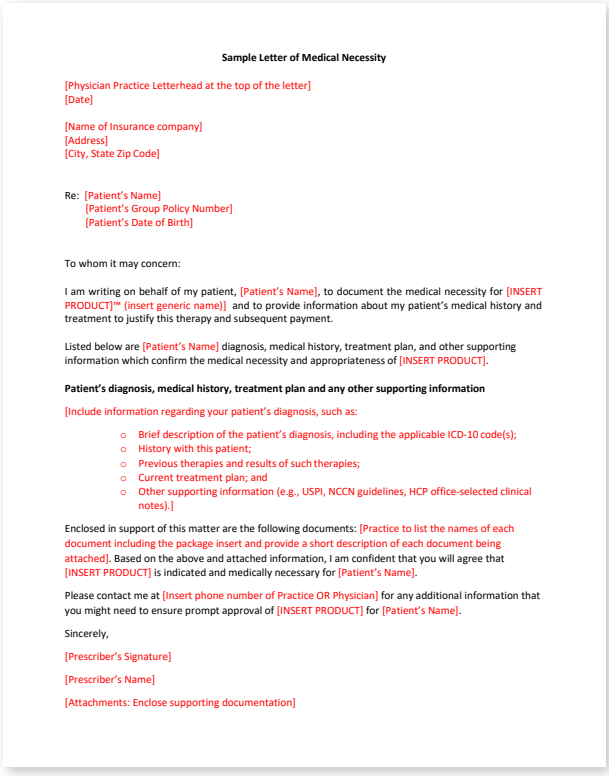
A **sample letter** is provided in this guide and available for download at **www.YourBlueprint.com/HCP**.

The sample letter is provided for information only and supplying the information with requests does not guarantee coverage for AYVAKIT. The information is not intended to substitute for or influence the physician's independent clinical decision.

SAMPLE COVERAGE DETERMINATION REQUEST LETTERS

Sample Letter of Medical Necessity

For use when submitting a PA (see checklist on page 14)



Sample Letter of Medical Necessity

[Physician Practice Letterhead at the top of the letter]
[Date]

[Name of Insurance company]
[Address]
[City, State Zip Code]

Re: [Patient's Name]
[Patient's Group Policy Number]
[Patient's Date of Birth]

To whom it may concern:

I am writing on behalf of my patient, [Patient's Name], to document the medical necessity for [INSERT PRODUCT]™ (insert generic name)] and to provide information about my patient's medical history and treatment to justify this therapy and subsequent payment.

Listed below are [Patient's Name] diagnosis, medical history, treatment plan, and other supporting information which confirm the medical necessity and appropriateness of [INSERT PRODUCT].

Patient's diagnosis, medical history, treatment plan and any other supporting information

[Include information regarding your patient's diagnosis, such as:

- Brief description of the patient's diagnosis, including the applicable ICD-10 code(s);
- History with this patient;
- Previous therapies and results of such therapies;
- Current treatment plan; and
- Other supporting information (e.g., USPI, NCCN guidelines, HCP office-selected clinical notes).]

Enclosed in support of this matter are the following documents: [Practice to list the names of each document including the package insert and provide a short description of each document being attached]. Based on the above and attached information, I am confident that you will agree that [INSERT PRODUCT] is indicated and medically necessary for [Patient's Name].

Please contact me at [Insert phone number of Practice OR Physician] for any additional information that you might need to ensure prompt approval of [INSERT PRODUCT] for [Patient's Name].

Sincerely,

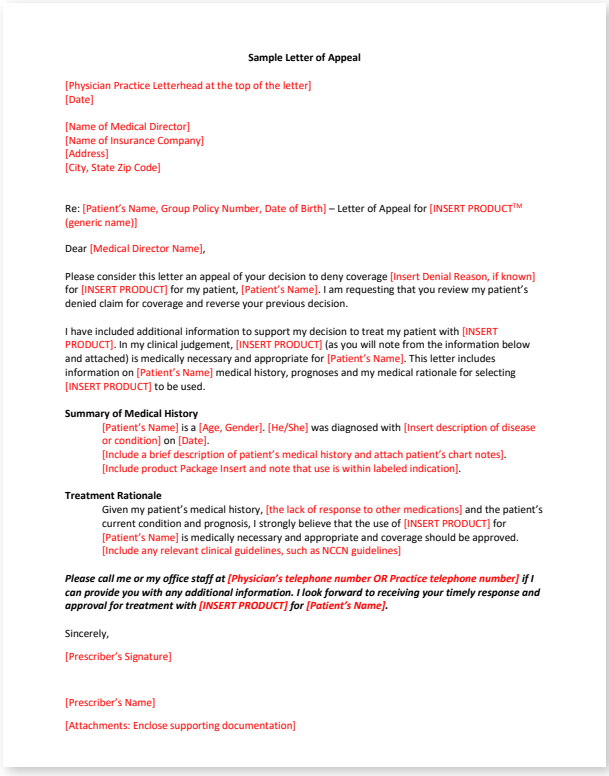
[Prescriber's Signature]

[Prescriber's Name]

[Attachments: Enclose supporting documentation]

Sample Letter of Appeal

For use when appealing a coverage denial (see page 15)



Sample Letter of Appeal

[Physician Practice Letterhead at the top of the letter]
[Date]

[Name of Medical Director]
[Name of Insurance Company]
[Address]
[City, State Zip Code]

Re: [Patient's Name, Group Policy Number, Date of Birth] – Letter of Appeal for [INSERT PRODUCT™ (generic name)]

Dear [Medical Director Name],

Please consider this letter an appeal of your decision to deny coverage [Insert Denial Reason, if known] for [INSERT PRODUCT] for my patient, [Patient's Name]. I am requesting that you review my patient's denied claim for coverage and reverse your previous decision.

I have included additional information to support my decision to treat my patient with [INSERT PRODUCT]. In my clinical judgement, [INSERT PRODUCT] (as you will note from the information below and attached) is medically necessary and appropriate for [Patient's Name]. This letter includes information on [Patient's Name] medical history, prognoses and my medical rationale for selecting [INSERT PRODUCT] to be used.

Summary of Medical History

[Patient's Name] is a [Age, Gender]. [He/She] was diagnosed with [Insert description of disease or condition] on [Date].
[Include a brief description of patient's medical history and attach patient's chart notes].
[Include product Package Insert and note that use is within labeled indication].

Treatment Rationale

Given my patient's medical history, [the lack of response to other medications] and the patient's current condition and prognosis, I strongly believe that the use of [INSERT PRODUCT] for [Patient's Name] is medically necessary and appropriate and coverage should be approved.
[Include any relevant clinical guidelines, such as NCCN guidelines]

Please call me or my office staff at [Physician's telephone number OR Practice telephone number] if I can provide you with any additional information. I look forward to receiving your timely response and approval for treatment with [INSERT PRODUCT] for [Patient's Name].

Sincerely,

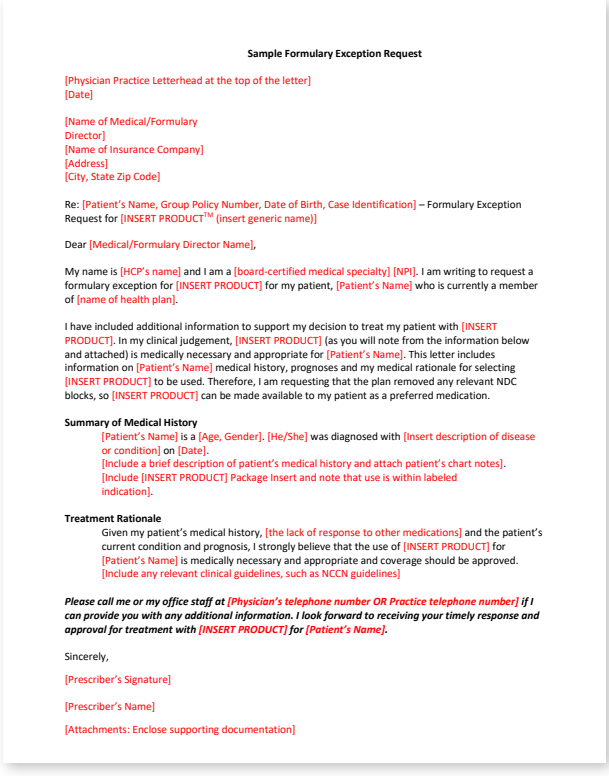
[Prescriber's Signature]

[Prescriber's Name]

[Attachments: Enclose supporting documentation]

Sample Formulary Exception Request

For use when requesting a coverage exception when a drug is not yet covered on formulary (see page 15)



Sample Formulary Exception Request

[Physician Practice Letterhead at the top of the letter]
[Date]

[Name of Medical/Formulary Director]
[Name of Insurance Company]
[Address]
[City, State Zip Code]

Re: [Patient's Name, Group Policy Number, Date of Birth, Case Identification] – Formulary Exception Request for [INSERT PRODUCT™ (insert generic name)]

Dear [Medical/Formulary Director Name],

My name is [HCP's name] and I am a [board-certified medical specialty] [NPI]. I am writing to request a formulary exception for [INSERT PRODUCT] for my patient, [Patient's Name] who is currently a member of [name of health plan].

I have included additional information to support my decision to treat my patient with [INSERT PRODUCT]. In my clinical judgement, [INSERT PRODUCT] (as you will note from the information below and attached) is medically necessary and appropriate for [Patient's Name]. This letter includes information on [Patient's Name] medical history, prognoses and my medical rationale for selecting [INSERT PRODUCT] to be used. Therefore, I am requesting that the plan removed any relevant NDC blocks, so [INSERT PRODUCT] can be made available to my patient as a preferred medication.

Summary of Medical History

[Patient's Name] is a [Age, Gender]. [He/She] was diagnosed with [Insert description of disease or condition] on [Date].
[Include a brief description of patient's medical history and attach patient's chart notes].
[Include [INSERT PRODUCT] Package Insert and note that use is within labeled indication].

Treatment Rationale

Given my patient's medical history, [the lack of response to other medications] and the patient's current condition and prognosis, I strongly believe that the use of [INSERT PRODUCT] for [Patient's Name] is medically necessary and appropriate and coverage should be approved.
[Include any relevant clinical guidelines, such as NCCN guidelines]

Please call me or my office staff at [Physician's telephone number OR Practice telephone number] if I can provide you with any additional information. I look forward to receiving your timely response and approval for treatment with [INSERT PRODUCT] for [Patient's Name].

Sincerely,

[Prescriber's Signature]

[Prescriber's Name]

[Attachments: Enclose supporting documentation]

Electronic versions of these sample letters are available on www.YourBlueprint.com/HCP

Diagnostic Testing & Coding

Advanced Systemic Mastocytosis (AdvSM) and Indolent Systemic Mastocytosis (ISM)

DIAGNOSTIC TESTING

Commercial Laboratories Currently Offering High-Sensitivity *KIT* D816V Assays*

Lab	Website
ARUP Laboratories[1,2]	www.aruplab.com
Labcorp[3]	www.labcorp.com
Mayo Clinic Laboratories[4]	www.mayocliniclabs.com
Virant Diagnostics[5]	www.virantdx.com

*Some academic centers may also offer a high sensitivity *KIT* D816V assay

This list is not intended to be a recommendation, referral or endorsement of a specific laboratory, service, or test. Blueprint Medicines Corporation makes no representations, assumes no liability, and provides no warranties regarding the clinical or analytical validity, quality, or design of the testing or services included. Blueprint Medicines is not responsible for the content of these websites and makes no guarantee about the accuracy of the information or the quality of services provided. This list is provided as a convenience only and may not be exhaustive. Blueprint Medicines may update this list from time to time as it becomes aware of other commercial laboratories offering high-sensitivity *KIT* D816V testing. Lab selection and the need to order a high sensitivity test is at the discretion of the ordering physician's medical judgment.

CODING FOR DIAGNOSTIC TESTS

The codes provided below are information only. Coding is a clinical decision that can only be made by a provider based on the condition of the patient being treated. The use of the following codes does not suggest or guarantee reimbursement and may not be comprehensive. The testing codes listed are current as of May 2023 and are subject to change. Test codes are individual administrative codes assigned by the individual lab. Providers should confirm with a lab prior to ordering a test.

Relevant CPT Codes[4] For Serum Tryptase and Peripheral Blood Assays

CPT Code	Short Descriptor
81273	*KIT* D816V mutational testing
83520	Serum tryptase

THE PRESENCE OF A *KIT* D816V MUTATION IS NOT REQUIRED BY THE PRESCRIBING INFORMATION.

KIT, *KIT* proto-oncogene receptor tyrosine kinase; **CPT**, correct procedural terminology.

DIAGNOSIS CODES FOR THE IDENTIFICATION OF ADVANCED SM

Based on the AdvSM indications for AYVAKIT®, examples of diagnosis codes that may be appropriate are listed below. The codes provided below are information only. Coding is a clinical decision that can only be made by a provider based on the condition of the patient being treated. The use of the following codes does not suggest or guarantee reimbursement and may not be comprehensive. The testing codes listed are current as of May 2023 and are subject to change. Test codes are individual administrative codes assigned by the individual lab. Providers should confirm with a lab prior to ordering a test.

ICD-10 Diagnosis Codes

Code	Description
D47.02	Systemic mastocytosis
D47.09	Other mast cell neoplasms of uncertain behavior
C94.30	Mast cell leukemia, not having achieved remission
C94.31	Mast cell leukemia, in remission
C94.32	Mast cell leukemia, in relapse
C96.21	Aggressive systemic mastocytosis

DIAGNOSIS CODES FOR THE IDENTIFICATION OF INDOLENT SYSTEMIC MASTOCYTOSIS

Based on the ISM indications for AYVAKIT, examples of diagnosis codes that may be appropriate are listed below. The codes provided below are information only. Coding is a clinical decision that can only be made by a provider based on the condition of the patient being treated. The use of the following codes does not suggest or guarantee reimbursement and may not be comprehensive. The testing codes listed are current as of May 2023 and are subject to change. Test codes are individual administrative codes assigned by the individual lab. Providers should confirm with a lab prior to ordering a test.

ICD-10 Diagnosis Codes

Code	Description
D47.02	Systemic mastocytosis
D47.09	Other mast cell neoplasms of uncertain behavior

PDGFRA Exon 18 Mutation-Positive Unresectable or Metastatic GIST

Select GIST patients for treatment with AYVAKIT® based on the presence of a PDGFRA exon 18 mutation.

DIAGNOSTIC TESTING

Select GIST patients for treatment with AYVAKIT based on the presence of a PDGFRA exon 18 mutation.

- PDGFRA D842V is a primary driver mutation in 5%-6% of GIST cases.[7]

CODING FOR DIAGNOSTIC TESTS

The codes provided below are information only. Coding is a clinical decision that can only be made by a provider based on the condition of the patient being treated. The use of the following codes does not suggest or guarantee reimbursement and may not be comprehensive. The testing codes listed are current as of May 2023 and are subject to change. Test codes are individual administrative codes assigned by the individual lab. Providers should confirm with a lab prior to ordering a test.

Relevant CPT Codes[6] for GIST-Related Tests

CPT Code	Short Descriptor
81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (e.g., gastrointestinal stromal tumor [GIST]), gene analysis, targeted sequence analysis (e.g., exons 12, 18)
81272	*KIT* (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (e.g., gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (e.g., exons 8, 11, 13, 17, 18)
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure

DIAGNOSIS CODES FOR THE IDENTIFICATION OF GIST

Based on the PDGFRA Exon 18 Mutation-Positive Unresectable or Metastatic GIST indication for AYVAKIT, examples of diagnosis codes that may be appropriate are listed below. The codes provided below are information only. Coding is a clinical decision that can only be made by a provider based on the condition of the patient being treated. The use of the following codes does not suggest or guarantee reimbursement and may not be comprehensive. The testing codes listed are current as of May 2023 and are subject to change. Test codes are individual administrative codes assigned by the individual lab. Providers should confirm with a lab prior to ordering a test.

ICD-10 Diagnosis Codes

Code	Description
C49.A0	Gastrointestinal stromal tumor, unspecified site
C49.A1	Gastrointestinal stromal tumor of esophagus
C49.A2	Gastrointestinal stromal tumor of stomach
C49.A3	Gastrointestinal stromal tumor of small intestine
C49.A4	Gastrointestinal stromal tumor of large intestine
C49.A5	Gastrointestinal stromal tumor of rectum
C49.A9	Gastrointestinal stromal tumor of other sites

PDGFRA, platelet-derived growth factor receptor alpha.

REFERENCES:

1. Arup Laboratories. *KIT* (*KIT* (D816V) Mutation by ddPCR, Quantitative. https://ltd.aruplab.com/Tests/Pub/3002956. Accessed April 12, 2023.
2. Arup Laboratories. *KIT* Molecular Testing. https://ltd.aruplab.com/api/ltd/pdf/294. Accessed April 12, 2023.
3. Labcorp. *KIT* (D816V) Digital PCR. https://www.labcorp.com/tests/485126/kit-d816v-digital-pcr. Accessed April 12, 2023.
4. Mayo Clinic Laboratories. https://www.mayocliniclabs.com/test-catalog/index.html. Accessed April 12, 2023.
5. Virant Diagnostics. KIT [D816V] Testing. https://virantdx.com/testing-solutions/genetic-testing/mcd/. Accessed April 12, 2023.
6. American Medical Association. CPT® 2020 Professional Edition.
7. Corless CL, et al. *J Clin Oncol.* 2005;23(23):5357-5364.

Please see the Important Safety Information on pages 3-4 and full Prescribing Information for AYVAKIT.