How to complete the YourBlueprint® Patient Support Program enrollment form

YourBlueprint is a patient support program that assists eligible patients throughout many aspects of treatment by providing a variety of support along the treatment journey.

To ensure there is no delay in patient access to prescribed therapy, be sure to completely fill in the enrollment form, including patient signatures and HCP signature. If the patient isn't able to sign in person, the patient can submit their signature through DocuSign at www.yourblueprint.com/consent.

Submitting the enrollment form to YourBlueprint at the time of prescribing will enable the YourBlueprint team to proactively support your patient's access needs.

1 Enter complete **patient information** and include pre-approval program participant information (EAP, CUP or Clinical Trial) if applicable

2 If patient may need to apply for PAP, enter the **number of people within their household**

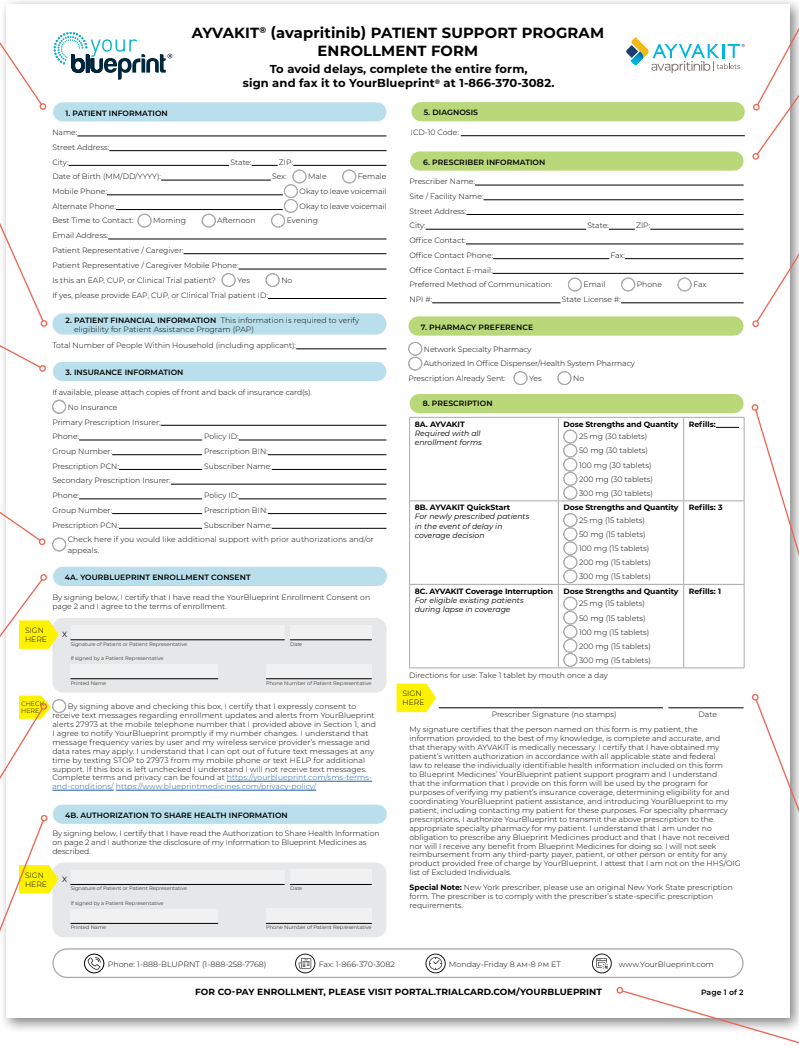
3 Enter complete **patient insurance information**, notably their prescription drug insurer. Please attach a copy of the patient's insurance card (front and back). If patient does not have insurance, please select "No Insurance"

Select for **PA and/or Appeal support**. If you have started the PA process, please make YourBlueprint team aware

4A Patient to complete YourBlueprint **enrollment consent**. If patient is not able to sign at time of enrollment form submission, they can sign consent via DocuSign at **www.yourblueprint.com/consent**

Please check this box if you would like to receive **text messages** from YourBlueprint

4B Patient to complete **authorization to share health information**. If patient is not able to sign at time of enrollment form submission, they can sign authorization via DocuSign at **www.yourblueprint.com/consent**



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.

AYVAKIT® avapritinib | tablets

1. PATIENT INFORMATION

Name:
Street Address:
City: State: ZIP:
Date of Birth (MM/DD/YYYY): Sex: ◯ Male ◯ Female
Mobile 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 Mobile Phone:
Is this an EAP, CUP, or Clinical Trial patient? ◯ Yes ◯ No
If yes, please provide EAP, CUP, or Clinical Trial patient ID:

2. PATIENT FINANCIAL INFORMATION This information is required to verify eligibility for Patient Assistance Program (PAP)

Total Number of People Within Household (including applicant):

3. INSURANCE INFORMATION

If available, please attach copies of front and back of insurance card(s).
◯ No Insurance
Primary Prescription Insurer:
Phone: Policy ID:
Group Number: Prescription BIN:
Prescription PCN: Subscriber Name:
Secondary Prescription Insurer:
Phone: Policy ID:
Group Number: Prescription BIN:
Prescription PCN: Subscriber Name:
◯ Check here if you would like additional support with prior authorizations and/or appeals.

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

CHECK HERE ◯ By signing above and checking this box, I certify that I expressly consent to receive text messages regarding enrollment updates and alerts from YourBlueprint alerts 27973 at the mobile telephone number that I provided above in Section 1, and I agree to notify YourBlueprint promptly if my number changes. I understand that message frequency varies by user and my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by texting STOP to 27973 from my mobile phone or text HELP for additional support. If this box is left unchecked I understand I will not receive text messages. Complete terms and privacy can be found at https://yourblueprint.com/sms-terms-and-conditions/ https://www.blueprintmedicines.com/privacy-policy/

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

ICD-10 Code:

6. PRESCRIBER INFORMATION

Prescriber Name:
Site / Facility Name:
Street Address:
City: State: ZIP:
Office Contact:
Office Contact Phone: Fax:
Office Contact E-mail:
Preferred Method of Communication: ◯ Email ◯ Phone ◯ Fax
NPI #: State License #:

7. PHARMACY PREFERENCE

◯ Network Specialty Pharmacy
◯ Authorized In Office Dispenser/Health System Pharmacy
Prescription Already Sent: ◯ Yes ◯ No

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

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 AYVAKIT 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, determining eligibility for and coordinating YourBlueprint patient assistance, and introducing YourBlueprint to my patient, including contacting my patient 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.

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

5 Enter complete **ICD-10 Code**

6 Enter full **prescriber and office contact information**

7 Please indicate whether your patient would like to fill their prescription at one of our in **Network Specialty Pharmacies or an Authorized In Office Dispenser/Health System Pharmacy**. Select Yes if prescription has already been sent

8 Enter appropriate **prescription, dose, and refills**

- Prescription 8A can either be forwarded to an in-network pharmacy or used for PAP dispensing
- Prescription 8B will be used for QuickStart dispensing. Submit date of PA submission with enrollment form if applicable
- Prescription 8C will be used for Coverage Interruption dispensing

Selecting all three will ensure that patient can access all programs, if needed

Ensure **prescribing physician signs and dates** the prescription

If your commercially insured patient would like to **enroll in copay support**, you can enroll them electronically through the enrollment portal

Submit the enrollment form to YourBlueprint by:

Fax: **1-866-370-3082** OR Email: **info@yourblueprint.com**

Reimbursement Support

What is it?

Your patient's dedicated Case Manager 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 for additional support with prior authorizations and appeals at the end of **Section 3**
- ☐ Ensure patient's insurance information is completed on the form and attach copies of the front and back of insurance card(s)

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

Copay Assistance

What is it?

For eligible patients enrolled in copay 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. Terms and conditions apply. Please call 1-888-BLUPRNT (1-888-258-7768) to learn more.

What do we need from you?

- ☐ Enroll your patient via the online portal at **portal.trialcard.com/yourblueprint**
- ☐ 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 copay processor to adjudicate claims. Visit **yourblueprint.com** for a comprehensive guide on contracting with our copay processor, or contact your Blueprint Medicines Sales Representative.

Quick Start

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 a limited supply of no-cost medication pending a final coverage 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

Dose Exchange

What is it?

Should the patient experience a dose modification while on AYVAKIT, the patient may exchange 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 YourBlueprint

Access the form at **YourBlueprint.com/dose-exchange**

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 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

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