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Deciphera AccessPoint™ Enrollment Form for ROMVIMZA™ (vimseltinib)

PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 1-833-DCPH-FAX (1-833-327-4329).
Deciphera AccessPoint will acknowledge receipt. For assistance, call 1-833-4DACCES (1-833-432-2237).

Access a digital enrollment form at DAPenroll.com, or e-prescribe directly to Pharmacord Pharmacy (NCPDP Number 1836191).

*Denotes a required field. Failure to fill in all required fields may lead to fulfillment delays.

Clinical Trial Patient ID:

1. PATIENT INFORMATION

*First Name: *Last Name: *Date of Birth (MM/DD/YYYY):

Gender: Male Female *Home Phone: *Mobile Phone:

Street Address: City: State: ZIP:

Email (required for some educational services): Preferred Contact Method: Call Email Text

***OK to Text?:** Yes No ***OK to Leave Voicemail?:** Yes No

Primary Language: English Spanish Other: 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).

PRIMARY INSURANCE Coverage: Medicare Medicaid Commercial / Private Other Uninsured

Insurer Name: Policy Holder Name: Relationship to Patient:

Phone: Policy ID: Group Number: Policy Holder Date of Birth:

Employer Name: Does this patient have a separate pharmacy benefit card? Yes No

Name of Pharmacy Benefits Manager: Policy ID:

Group Number: BIN Number: PCN Number: Phone:

SECONDARY INSURANCE Coverage: Medicare Medicaid Commercial / Private Other Uninsured

Insurer Name: Policy Holder Name: Relationship to Patient:

Phone: Policy ID: Group Number: Policy Holder Date of Birth:

Does this patient have a separate pharmacy benefit card? Yes No

Name of Pharmacy Benefits Manager: Policy ID:

Group Number: BIN Number: PCN Number: Phone:

3. PATIENT INSURANCE STATUS

A Deciphera AccessPoint case manager will verify your patient's insurance coverage for ROMVIMZA. Please share any coverage information you've already obtained.

Has a prior authorization (PA) been initiated? Yes No If "yes", PA Status: Approved Denied Pending

Has an appeal been initiated? Yes No If "yes" Appeal Status: Approved Denied Pending

If "Approved", copay amount: $

Please attach any relevant insurer approval or denial letters.

4. CLINICAL INFORMATION

*Primary Diagnosis ICD-10: Secondary Diagnosis ICD-10:

Type of TGCT: Localized Diffuse Joint/Location Affected by TGCT:

*Please list names of prior tyrosine kinase inhibitors (TKIs) received (oldest to most recent): OR Treatment Naive

Number of surgeries for TGCT: Has the patient previously been treated with steroids or NSAIDs? Yes No

New to ROMVIMZA Restarting ROMVIMZA Currently taking ROMVIMZA ROMVIMZA start date:

Current Medication(s) (list all): OR Current Medication List Included/Attached

Known Drug Allergies: Clinical Notes Included/Attached

1-833-4DACCES (1-833-432-2237) Monday–Friday 8AM–8PM ET 1-833-DCPH-FAX (1-833-327-4329) decipheraaccesspoint.com DAPenroll.com

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*Patient Name: *Patient Date of Birth:

5.PRESCRIBER INFORMATION

*Prescriber Name (first, last): Prescriber Title:
*NPI Number: DEA Number: Prescriber Specialty:
Site / Facility Name:
*Street Address: *City: *State: *ZIP:
Office Contact: *Phone: Fax:
Email: Preferred Contact Method: Phone Email Fax
Supervisory Prescriber Name (first, last): Supervisory Prescriber NPI Number:

6. PRESCRIPTION FOR ROMVIMZA

Complete BOTH Sections

ROMVIMZA RX Refills:
Dispense Qty: 1 package of 8 capsules 30 MG 20 MG 14 MG
Recommended directions for use: take 1 capsule by mouth twice per week at least 72 hours apart.
Alternative Directions for Use:
Dispense as written, no substitution

Sign Here: Date:

ROMVIMZA Temporary Supply RX 5 Refills
Due to coverage delay or interruption 30 MG 20 MG 14 MG
Rapid Start (New Patients)/Bridge (Continuing Patients)
Dispense Qty: 1 package of 4 capsules
Recommended directions for use: take 1 capsule by mouth twice per week at least 72 hours apart.
Alternative Directions for Use:
Dispense as written, no substitution

Sign Here: Date:

Rapid Start and Bridge Program: Patients with private or government insurance receive 14-day supplies of ROMVIMZA for free, up to 84 days, in the event of a delay in insurance coverage investigations for a new patient or a lapse in insurance coverage for an established patient. Patients must not seek reimbursement or credit for this prescription from any insurer, health plan, or provider. By signing above, I certify that I understand the Rapid Start and Bridge Program terms and agree that I shall not seek reimbursement for ROMVIMZA obtained through the Rapid Start or Bridge Programs.

All, please note: My signature above 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 ROMVIMZA 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 ROMVIMZA support services to my patient, including contacting my patient by telephone or mail for these purposes. I authorize Deciphera AccessPoint for ROMVIMZA 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. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

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*Patient Name: *Patient Date of Birth:

7.PREFERRED SPECIALTY PHARMACY

ROMVIMZA is available through select specialty pharmacies (Biologics by McKesson, Onco360, and eligible in-office dispensing locations).
If your patient's preferred specialty pharmacy is unable to fill for your patient's insurance plan, Deciphera AccessPoint can help find a pharmacy to fill.

Patient's Preferred Pharmacy: Biologics by McKesson Onco360 Eligible in-office dispensing site

If preferred pharmacy is an eligible in-office dispensing site:

Pharmacy Name: Contact Name:

Pharmacy NPI: Phone: Fax:

Has a prescription for ROMVIMZA already been sent to a pharmacy? Yes No

If "yes": Date Prescribed: If "yes": Pharmacy Name:

8. REASON FOR REFERRAL

Deciphera AccessPoint offers services to ROMVIMZA patients based on their individual needs. Which of these services are most relevant for your patient? (Check all that apply):

- PA/Appeal Support
- Benefits Investigation
- Copay Assistance Program
- Rapid Start (temporary supply program for new patients)
- Bridge Support (temporary supply program for established patients)
- Patient Assistance Program
- Dispensing through a Network Pharmacy
- ROMVIMZA and TGCT Education and Materials
- Nurse Outreach Program
- Dose Modification

Tell us more about the reason for your referral or provide us with any important background information (optional):

Note for in-office dispense locations: Participation in Deciphera AccessPoint does not require re-routing of prescriptions from eligible in-office dispensaries to specialty pharmacies. Confirm your pharmacy choice in Section 7 of this form.

9. PATIENT FINANCIAL INFORMATION (required to verify eligibility for Patient Assistance Program)

Number of Household Members (including applicant): Annual Gross Household Income: $

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Enrollment Consent and Privacy Authorization

*Patient Name: *Patient Date of Birth:

CONSENT FOR ENROLLMENT IN DECIPHERA ACCESSPOINT AND PATIENT ASSISTANCE PROGRAM

By signing below, I am enrolling in Deciphera AccessPoint for ROMVIMZA™ (vimseltinib) 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, as well as contact me via text and voicemail. 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.

Sign Here: Date: If signed by a patient representative:

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 ROMVIMZA (my "Information") to (1) enroll me in and provide services under the Deciphera AccessPoint for ROMVIMZA 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 ROMVIMZA 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.

Sign Here: Date: If signed by a patient representative:

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

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