decipheraAccessPoint™

Deciphera AccessPoint™ Enrollment Form

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 Deciphera AccessPoint at 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).
11001 Bluegrass Parkway Suite 200 Louisville, KY 40299.

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

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
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: _____
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 QINLOCK® (ripretinib). 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", PA 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: _____
*Please list names of prior tyrosine kinase inhibitors (TKIs) received by line of therapy:
☐ 1st line: _____ ☐ 2nd line: _____ ☐ 3rd line: _____
☐ 4th line and beyond: _____

Patient is: ◯ New to QINLOCK ◯ Currently taking QINLOCK QINLOCK start date: _____
Current Medication(s) (list all): _____
OR ◯ Current Medication List Included/Attached
Concomitant use of moderate CYP3A inducer and QINLOCK (if applicable): ◯ Yes ◯ No
Known Drug Allergies: _____
◯ Clinical Notes Included/Attached

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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 QINLOCK® (ripretinib)

***Complete EITHER Section A (New Patient) OR section B (Existing Patient):**

A - NEW PATIENT

QINLOCK (ripretinib) Rx Refills: _____

50 mg tablets, 90-count bottle

☐ Recommended dose: 150 mg (3 tablets by mouth once daily)

☐ Alternate dose: _____

Dispense as written, no substitution.

Sign here: _____ Date: _____

Prescriber Signature (no stamps)

and

QINLOCK (ripretinib) Rapid Start Rx 5 Refills

50 mg tablets, 30-count bottle

Select for a new patient, not yet on therapy, in the event of an insurance-related delay

☐ Recommended dose: 150 mg (3 tablets by mouth once daily)

☐ Alternate dose: _____

Dispense as written, no substitution.

Sign here: _____ Date: _____

Prescriber Signature (no stamps)

Rapid Start: Patients with private or government insurance receive 10-day supplies of QINLOCK® (ripretinib), up to 60 days, in event of a delay in insurance coverage investigations. Patients must have an on-label prescription and 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 program terms and agree that I shall not seek reimbursement for QINLOCK® (ripretinib) dispensed through the Rapid Start program.

OR

B - EXISTING PATIENT

QINLOCK (ripretinib) Ongoing Rx Refills: _____

50 mg tablets, 90-count bottle

☐ Recommended dose: 150 mg (3 tablets by mouth once daily)

☐ Alternate dose: _____

Dispense as written, no substitution.

Sign here: _____ Date: _____

Prescriber Signature (no stamps)

and

QINLOCK (ripretinib) Bridge Rx 5 Refills

50 mg tablets, 30-count bottle

Select for a patient who has already been on therapy, in the event of coverage interruption

☐ Recommended dose: 150 mg (3 tablets by mouth once daily)

☐ Alternate dose: _____

Dispense as written, no substitution.

Sign here: _____ Date: _____

Prescriber Signature (no stamps)

Bridge Program: Patients with private or government insurance may be eligible to receive 10-day supplies of QINLOCK® (ripretinib), up to 60 days, in event of a lapse in insurance coverage. 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 Bridge Program terms and agree that I shall not seek reimbursement for QINLOCK® (ripretinib) dispensed through the Bridge Program.

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 QINLOCK® (ripretinib) 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 QINLOCK® (ripretinib) support services to my patient, including contacting my patient by telephone or mail for these purposes. I authorize Deciphera AccessPoint for QINLOCK® (ripretinib) 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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7. PREFERRED SPECIALTY PHARMACY

QINLOCK® (ripretinib) is available through select specialty pharmacies (PANTHERx Rare Pharmacy, US Bioservices, Biologics, 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: ◯ PANTHERx Rare Pharmacy ◯ US Bioservices ◯ Biologics ◯ Eligible in-office dispensing site

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

Pharmacy NPI:_____ Contact Name:_____

Phone:_____ Fax:_____

Has a prescription for QINLOCK already been sent to a pharmacy?

◯ Yes ◯ No If "yes": Date Prescribed:_____ Pharmacy Name:_____

8. REASON FOR REFERRAL

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

- ☐ BI/PA/Appeal Support
- ☐ Copay Assistance Program
- ☐ Rapid Start (temporary supply program for new patients)
- ☐ Bridge Support (temporary supply program for existing patients)
- ☐ Patient Assistance Program
- ☐ Dispensing through a Network Pharmacy
- ☐ QINLOCK and GIST Education and Materials
- ☐ Nurse Outreach Program

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 QINLOCK® (ripretinib) 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. 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.

If signed by a patient representative:

Sign here: _____ Date: _____ _____ _____

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

If signed by a patient representative:

Sign here: _____ Date: _____ _____ _____

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

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