EveryDay Support From Day One™
Enrollment Form

Day One BIOPHARMACEUTICALS

855-DAY1-BIO/855-329-1246 | 855-332-9663 | Monday–Friday 8 AM–8 PM ET | www.everydaysupport.com

Instructions for Prescribers:

1. Please review and complete pages 1-2 to initiate enrollment for your patient.
2. Return via fax to EveryDay Support From Day One at **855-332-9663** or email **info@everydaysupport.com**.

Prescribers to complete blue sections

Instructions for Patients: Please complete the Patient Information section below, review the Patient Authorization section on pages 3-4, and provide consent in one of the following ways:

1. Visit **www.everydaysupport.com/consent**.
2. Sign page 4 and email it to **info@everydaysupport.com**.
3. Fill out and sign the form with your doctor. Your doctor will submit all 4 pages.

Patients to review and complete yellow sections

PATIENT INFORMATION (For prescriber or patient to complete)

Patient First Name: _____ Patient Last Name: _____

Date of Birth (DOB): ____ /____ /_____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Parent/Legal Guardian Name: _____ Relationship to Patient: _____

Patient Street Address: _____

House/Apt #: _____ City: _____ State: _____ ZIP: _____

Patient/Legal Guardian Email Address: _____

Primary Phone #: _____ Secondary Phone #: _____

Alternate Caregiver: _____ Relationship to Patient: _____

Primary Phone #: _____ Secondary Phone #: _____

INSURANCE INFORMATION

☐ Patient is uninsured

Please attach front and back copies of insurance card(s) or complete all applicable fields below.

	PRIMARY INSURANCE	PRESCRIPTION INSURANCE
PLAN NAME		
PLAN/POLICY ID #		
GROUP #		
Rx BIN		
Rx PCN		
SUBSCRIBER NAME		
SUBSCRIBER DATE OF BIRTH	____ /____ /_____	____ /____ /_____
CUSTOMER SERVICE #		

PRESCRIBER INFORMATION

First Name: _____ Last Name: _____

Prescriber NPI #: _____ Facility Name: _____

Facility Address: _____

Suite/Office #: _____ City: _____ State: _____ ZIP: _____

Office Contact: _____ Office Contact Title: _____

Office Email Address: _____

Office Phone #: _____ Office Fax #: _____

In-Network Specialty Pharmacy Preference: ☐ Biologics ☐ Onco360 ☐ No preference

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Day One BIOPHARMACEUTICALS

Patient First Name: _____ Patient Last Name: _____ DOB: ____ /____ /_____

Prescriber First Name: _____ Prescriber Last Name: _____ NPI #: _____

CLINICAL INFORMATION

Primary ICD-10-CM Code(s): _____ Patient Body Surface Area (BSA): _____

Patient Height: _____ ☐ in ☐ cm Patient Weight: _____ ☐ lbs ☐ kgs Date of Measurement: _____ /_____ /_____

PRESCRIPTION INFORMATION AND SIGNATURE

OJEMDA™ (tovorafenib) (Recommended dose: 380 mg/m²/once a week)

Prescription notes:

- It is recommended that patients with BSA ≤0.89 m² receive oral suspension
- For patients with BSA ≥0.90 m² who require oral suspension, please use "other" line in oral suspension section

COMPLETE PRESCRIPTION(S) BELOW OR INDICATE IF E-PRESCRIPTION WAS SUBMITTED

PRESCRIPTION FOR MAINTENANCE THERAPY

☐ Prescription sent to: _____ (pharmacy name). If checked, skip prescription fields below.

OJEMDA 25 mg/mL Oral Suspension (0.30 m² to 0.89 m² BSA)

- ☐ 0.30 m² to 0.35 m² BSA: Take 5 mL (125 mg) orally once weekly
- ☐ 0.36 m² to 0.42 m² BSA: Take 6 mL (150 mg) orally once weekly
- ☐ 0.43 m² to 0.48 m² BSA: Take 7 mL (175 mg) orally once weekly
- ☐ 0.49 m² to 0.54 m² BSA: Take 8 mL (200 mg) orally once weekly
- ☐ 0.55 m² to 0.63 m² BSA: Take 9 mL (225 mg) orally once weekly
- ☐ 0.64 m² to 0.77 m² BSA: Take 11 mL (275 mg) orally once weekly
- ☐ 0.78 m² to 0.83 m² BSA: Take 12 mL (300 mg) orally once weekly
- ☐ 0.84 m² to 0.89 m² BSA: Take 14 mL (350 mg) orally once weekly
- ☐ Other: _____ m² BSA: Take_____ mL (_____ mg) orally once weekly

OJEMDA Tablets (≥0.90 m² BSA)

Each tablet is 100 mg

- ☐ 0.90 m² to 1.12 m² BSA: Take 400 mg orally once weekly
- ☐ 1.13 m² to 1.39 m² BSA: Take 500 mg orally once weekly
- ☐ ≥1.40 m² BSA: Take 600 mg orally once weekly
- ☐ Other: _____ m² BSA: Take _____ mg orally once weekly

Dispense quantity needed for 28 days with _____ refills.

PRESCRIPTION FOR QUICKSTART PROGRAM (in case of coverage delay)

Patient must have a diagnosis consistent with the FDA-approved indication.

☐ Prescription sent to RareMed Solutions (NPI #: 1043877996). If checked, skip prescription fields below.

OJEMDA 25 mg/mL Oral Suspension (0.30 m² to 0.89 m² BSA)

- ☐ 0.30 m² to 0.35 m² BSA: Take 5 mL (125 mg) orally once weekly
- ☐ 0.36 m² to 0.42 m² BSA: Take 6 mL (150 mg) orally once weekly
- ☐ 0.43 m² to 0.48 m² BSA: Take 7 mL (175 mg) orally once weekly
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- ☐ Other: _____ m² BSA: Take_____ mL (_____ mg) orally once weekly

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- ☐ ≥1.40 m² BSA: Take 600 mg orally once weekly
- ☐ Other: _____ m² BSA: Take _____ mg orally once weekly

Dispense quantity needed for up to 28 days with PRN (as needed) refills according to program rules.

My signature certifies that the person named on this form is my patient, the information provided is complete and accurate to the best of my knowledge, and that therapy with OJEMDA™ (tovorafenib) is medically necessary. I certify that I have obtained my patient's authorization in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Day One Biopharmaceuticals, Inc.'s ("Day One") EveryDay Support From Day One patient support program ("Program"), and I understand the information I provide on this form will be used for the purpose of verifying my patient's insurance, determining eligibility for Program offerings, and contacting my patient regarding Program support. I authorize the Program to transmit the above prescription to a specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Day One product and that I have not received, nor will I receive, any benefit from Day One 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 the Program. I attest that I am not on the HHS/OIG List of Excluded Individuals/Entities (LEIE).

Sign Here _____ _____ /_____ /_____

Prescriber Signature Date

Special Note: The prescriber is to comply with the prescriber's state-specific prescription requirements. New York prescriber, please use an original New York state prescription form.

FDA=US Food and Drug Administration; HHS=US Department of Health and Human Services; ICD-10-CM=International Classification of Diseases, 10th Revision, Clinical Modification; NPI=National Provider Identifier; OIG=Office of the Inspector General.

Scan QR code or visit **www.everydaysupport.com/consent** to submit the Patient Authorization online or continue to fill out below.

PATIENT AUTHORIZATION

For Disclosure of Personal Health Information, Program Participation and Marketing Materials

By signing below, I am enrolling in the EveryDay Support From Day One patient support program (the "Program"). I authorize Day One Biopharmaceuticals, Inc., its affiliates, business partners, vendors, and other agents ("Day One Biopharmaceuticals") to provide Program services for which I am eligible, which may include disease and medication education, medication and adherence communications, and related support services, including medication dispensing, insurance coverage and financial assistance. If eligible, I agree to my enrollment in the Copay Assistance Program. I authorize the Program to use my information and information from other sources to estimate my income, if needed, to assess eligibility for financial assistance programs. Upon request, the Program will provide me any consumer reporting agency's name and address that provided a report.

I understand that Day One Biopharmaceuticals, with my authorization, may use and share my information with my health care providers, pharmacies, and health insurance plans, to provide Program services, or as required to meet its legal obligations. I authorize Day One Biopharmaceuticals to contact me by mail, telephone, and email (and by text if I consent below) regarding the Program and to share information about Day One Biopharmaceuticals products, promotions, services, or research studies, which contact may include surveys about such information or the Program. I further authorize Day One Biopharmaceuticals to de-identify my information for use in performing research, education, business analytics, and marketing studies or for other purposes. This marketing may be based on the information I provide, including any health information shared above. I understand this Authorization expires ten years from the date signed below, or earlier under applicable law, unless I revoke it sooner. I understand that I may receive a copy of this Authorization. I understand I do not have to enroll in the Program, and if I do not enroll I can still receive my medication as prescribed by my physician. I understand that I may opt out of individual Program services, marketing communications or the Program entirely at any time by notifying the Program at 855-332-9663 or by writing to EveryDay Support From Day One at PO Box 15711, Pittsburgh, PA 15244.

AUTHORIZATION TO SHARE HEALTH INFORMATION

I authorize my health care providers, pharmacies, and health insurers to use and to disclose to Day One Biopharmaceuticals, Inc., its affiliates, business partners, vendors, and other agents (collectively, "Day One Biopharmaceuticals") my health information, including information about my medical condition and treatment, health insurance and claims, and prescriptions ("my Information") to enable my participation in the EveryDay Support From Day One patient support program (the "Program").

Continued on next page

AUTHORIZATION TO SHARE HEALTH INFORMATION (continued)

Once my Information has been disclosed, I understand that privacy laws may no longer protect it from further disclosure but that Day One Biopharmaceuticals will only use or disclose it as authorized by me or by law. By providing my email address, I acknowledge the risk associated with communicating personal health information via email and understand that Day One Biopharmaceuticals will use secure methods for storage and transmission. I understand the pharmacy that dispenses my medication may receive payment from Day One Biopharmaceuticals in exchange for my Information or for providing Program support services. I understand I may decide not to sign this Authorization, and such decision will not affect my ability to obtain medical treatment or medication from my health care providers or my eligibility for health insurance benefits. However, if I do not sign this Authorization, I will not be eligible for the Program. I understand that this Authorization expires ten years from the date signed below or earlier under applicable law, unless I revoke it sooner. I may revoke this Authorization at any time by calling 855-DAY1-BIO or by notifying EveryDay Support From Day One in writing at PO Box 15711, Pittsburgh, PA 15244. Revoking this Authorization will end future use and disclosure of my Information and my Program participation, but it will not affect any use or disclosure of my Information prior to its effective revocation. I understand I may request a signed copy of this Authorization.

☐ By checking here, I certify that **I expressly consent to receive text messages** regarding enrollment updates and alerts from EveryDay Support From Day One alerts at the mobile telephone number that I provided, and I agree to notify EveryDay Support From Day One promptly if my number changes. I understand 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 855-329-1246 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 of use and privacy policy can be found at www.dayonebio.com/privacy.

My signature certifies that I have read, understood, and agree to the release and use of my personal information pursuant to the Authorization to Use and Disclose Personal Information and as otherwise stated on this form.

Prescriber First Name: _____ Prescriber Last Name: _____

Patient First Name: _____ Patient Last Name: _____ DOB: ____ /____ /_____

Legal Guardian First Name: _____ Legal Guardian Last Name: _____

Sign Here _____ _____ /_____ /_____

Signature of Patient or Legal Guardian (if patient is under 18 years of age) Date

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