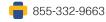
EveryDay Support From Day One™ Enrollment Form

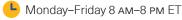


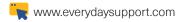


🔥 855-DAY1-BIO/855-329-1246

Patient First Name: __







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

PATIENT INFORMATION (For prescriber or patient to complete)

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

Parent/Legal Guardian Name: ______ Relationship to Patient: ___

Patient Street Address:				
				ZIP:
Patient/Legal Guardian Email A	Address:			
Primary Phone #:		Secondary Phor	ne #:	
Alternate Caregiver:	Relationship to Patient:			
Primary Phone #:		Secondary Phone #:		
	INSUR	ANCE INFORMATION		
Patient is uninsured				
Please attach front and back	copies of insurance card	l(s) or complete all appli	cable fields below	
	PRIMARY IN	ISURANCE	PRESC	RIPTION INSURANCE
PLAN NAME				
PLAN/POLICY ID #				
GROUP#				
Rx BIN				
Rx PCN				
SUBSCRIBER NAME				
SUBSCRIBER DATE OF BIRTH	//	· 		_//
CUSTOMER SERVICE #				
	PRESCI	RIBER INFORMATION	N	
First Name:	Last î	Name:		
Prescriber NPI#:	Facility Name:			
Facility Address:				
Suite/Office #:	City:		State:	ZIP:
Office Email Address:				
	Office Fax #:			
In-Network Specialty Pharmacy	v Preference: Biologics	s ☐ Onco360 ☐ No	preference	
	, :::::::::::::::::::::::::::::::::::::		1	EveryDay

Patient Last Name: _



EveryDay Support From Day One™ **Enrollment Form**



Patient First Name:	Patient Last Name:		_ DOB:/		
Prescriber First Name:	Prescriber Last Name	e:	_ NPI #:		
	CLINICAL INFO	RMATION			
Primary ICD-10-CM Code(s):	P	atient Body Surface Area (BSA):			
	in cm Patient Weight:[-			
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 INDIC	ATE IF E-PRESCRIPTION WAS SU	BMITTED		
PRESCRIPTION FOR MAINTE Prescription sent to:		_ (pharmacy name). If checked, skip pre	scription fields below.		
0.30 m² to 0.35 m² BSA: Ta 0.36 m² to 0.42 m² BSA: Ta 0.43 m² to 0.48 m² BSA: Ta 0.49 m² to 0.54 m² BSA: Ta 0.55 m² to 0.63 m² BSA: Ta 0.64 m² to 0.77 m² BSA: Ta 0.78 m² to 0.83 m² BSA: Ta 0.84 m² to 0.89 m² BSA: Ta	ension (0.30 m² to 0.89 m² BSA) ke 5 mL (125 mg) orally once weekly ke 6 mL (150 mg) orally once weekly ke 7 mL (175 mg) orally once weekly ke 8 mL (200 mg) orally once weekly ke 9 mL (225 mg) orally once weekly ke 11 mL (275 mg) orally once weekly ke 12 mL (300 mg) orally once weekly ke 14 mL (350 mg) orally once weekly	OJEMDA Tablets (≥0.90 m² BSA) Each tablet is 100 mg □ 0.90 m² to 1.12 m² BSA: Take 40 □ 1.13 m² to 1.39 m² BSA: Take 50 □ ≥1.40 m² BSA: Take 600 mg ora □ Other: m² BSA: Take	00 mg orally once weekly Ily once weekly		
	Dispense quantity needed for 2	28 days with refills.			
Patient must have a diagnosis of	ART PROGRAM (in case of coverage dela consistent with the FDA-approved indicatio Med Solutions (NPI #: 1043877996). If ch	n.			
0.30 m² to 0.35 m² BSA: Ta 0.36 m² to 0.42 m² BSA: Ta 0.43 m² to 0.48 m² BSA: Ta 0.49 m² to 0.54 m² BSA: Ta 0.55 m² to 0.63 m² BSA: Ta 0.64 m² to 0.77 m² BSA: Ta 0.78 m² to 0.83 m² BSA: Ta 0.84 m² to 0.89 m² BSA: Ta 0.84 m² to 0.89 m² BSA: Ta	ension (0.30 m² to 0.89 m² BSA) ke 5 mL (125 mg) orally once weekly ke 6 mL (150 mg) orally once weekly ke 7 mL (175 mg) orally once weekly ke 8 mL (200 mg) orally once weekly ke 9 mL (225 mg) orally once weekly ke 11 mL (275 mg) orally once weekly ke 12 mL (300 mg) orally once weekly ke 14 mL (350 mg) orally once weekly Ke 14 mL (350 mg) orally once weekly	OJEMDA Tablets (≥0.90 m² BSA) Each tablet is 100 mg □ 0.90 m² to 1.12 m² BSA: Take 40 □ 1.13 m² to 1.39 m² BSA: Take 50 □ ≥1.40 m² BSA: Take 600 mg ora □ Other: m² BSA: Take	00 mg orally once weekly Illy once weekly mg orally once weekly		
Dispense quantity needed for up to 28 days with PRN (as needed) refills according to program rules.					
therapy with OJEMDA™ (tovorafenib) federal laws to release the individual From Day One patient support progrinsurance, determining eligibility for prescription to a specialty pharmacy will I receive, any benefit from Day O	n named on this form is my patient, the informating medically necessary. I certify that I have obtainly identifiable health information included on this am ("Program"), and I understand the information Program offerings, and contacting my patient register of the my patient. I understand that I am under noting the for doing so. I will not seek reimbursement from I attest that I am not on the HHS/OIG List of	ned my patient's authorization in accordance form to Day One Biopharmaceuticals, Inc.'s n I provide on this form will be used for the parding Program support. I authorize the Probligation to prescribe any Day One product	ce with all applicable state and s ("Day One") EveryDay Support burpose of verifying my patient's burpose to transmit the above and that I have not received, nor		

Sign Here

Prescriber Signature

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.















EveryDay Support From Day One[™] Enrollment Form





Scan QR code or visit <u>www.everydaysupport.com/consent</u> 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



855-DAY1-BIO/855-329-1246









EveryDay Support From Day One™ Enrollment Form



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	t Name:	Prescriber Last Name:	
Patient First Na	ame:	Patient Last Name:	DOB: //
Legal Guardiar	n First Name:	Legal Guardian Last Name:	
Sign Here	Signature of Patient or Legal G	uardian (if patient is under 18 years of age)	/ /



855-DAY1-BIO/855-329-1246





