

*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 Other *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's Name: _____ Policy Holder's Name: _____ Relationship to Patient: _____
Insurer's Phone: _____ Policy ID: _____ Group Number: _____ Policy Holder's 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
Insurer's Name: _____ Policy Holder's Name: _____ Relationship to Patient: _____
Insurer's Phone: _____ Policy ID: _____ Group Number: _____ Policy Holder's 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 Verastem Cares case manager will verify your patient's insurance coverage for AVMAPKI FAKZYNJA CO-PACK (avutometinib capsules; defactinib tablets). 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: _____ Low-Grade Serous Ovarian Cancer (LGSOC)

*Please name prior lines of therapy received:

1st Line: _____ 2nd Line: _____ 3rd Line: _____

4th Line and Beyond: _____

Patient is: New to AVMAPKI FAKZYNJA CO-PACK Currently taking AVMAPKI FAKZYNJA CO-PACK

AVMAPKI FAKZYNJA CO-PACK Start Date: _____



Patient's Name: _____ Patient's Date of Birth: _____

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

Known Drug Allergies: _____ Clinical Notes Included/Attached

Indication

AVMAPKI FAKZYNJA CO-PACK is indicated for the treatment of adult patients with *KRAS*-mutated recurrent low-grade serous ovarian cancer (LGSOC) who have received prior systemic therapy.

This indication is approved under accelerated approval based on tumor response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

Important Safety Information

Warnings and Precautions

- **Ocular Toxicities:** Ocular toxicities, including visual impairment and vitreoretinal disorders, occurred. Perform comprehensive ophthalmic evaluation at baseline, prior to cycle 2, every three cycles thereafter, and as clinically indicated. Withhold AVMAPKI FAKZYNJA CO-PACK for ocular toxicities until improvement at the same or reduced dose. Permanently discontinue AVMAPKI FAKZYNJA CO-PACK for any grade 4 toxicity.
- **Serious Skin Toxicities:** Skin toxicities, including photosensitivity and severe cutaneous adverse reactions (SCARs), occurred. Adhere to concomitant medications. Monitor for skin toxicities and interrupt, reduce or permanently discontinue AVMAPKI FAKZYNJA CO-PACK based on severity, tolerability and duration.
- **Hepatotoxicity:** Monitor liver function tests prior to each cycle, on day 15 of the first 4 cycles, and as clinically indicated. Withhold, reduce or discontinue AVMAPKI FAKZYNJA CO-PACK based on severity and persistence of abnormality.
- **Rhabdomyolysis:** Monitor creatine phosphokinase prior to the start of each cycle, on day 15 of the first four cycles, and as clinically indicated. If increased CPK occurs, evaluate patients for rhabdomyolysis or other causes. Withhold, reduce or permanently discontinue AVMAPKI FAKZYNJA CO-PACK based on severity and duration of the adverse reaction.
- **Embryo-Fetal Toxicity:** AVMAPKI FAKZYNJA CO-PACK can cause fetal harm. Advise patients of the potential risk to a fetus and to use effective contraception.

Adverse Reactions

The most common ($\geq 25\%$) adverse reactions, including laboratory abnormalities, were increased creatine phosphokinase, nausea, fatigue, increased aspartate aminotransferase, rash, diarrhea, musculoskeletal pain, edema, decreased hemoglobin, increased alanine aminotransferase, vomiting, increased blood bilirubin, increased triglycerides, decreased lymphocyte count, abdominal pain, dyspepsia, dermatitis acneiform, vitreoretinal disorders, increased alkaline phosphatase, stomatitis, pruritus, visual impairment, decreased platelet count, constipation, dry skin, dyspnea, cough, urinary tract infection, and decreased neutrophil count.

Drug Interactions

- **Strong and moderate CYP3A4 inhibitors:** Avoid concomitant use with AVMAPKI FAKZYNJA CO-PACK.
- **Strong and moderate CYP3A4 inducers:** Avoid concomitant use with AVMAPKI FAKZYNJA CO-PACK.
- **Warfarin:** Avoid concomitant use of AVMAPKI FAKZYNJA CO-PACK with warfarin and use an alternative to warfarin.
- **Gastric acid reducing agents:** Avoid concomitant use of AVMAPKI FAKZYNJA CO-PACK with proton pump inhibitors (PPIs) or H2 receptor antagonists. If use of an acid-reducing agent cannot be avoided, administer FAKZYNJA 2 hours before or 2 hours after the administration of a locally acting antacid.

Use in Specific Populations

- **Lactation:** Advise not to breastfeed.
- **Fertility:** May impair fertility in males and females.

Click here for full [Prescribing Information](#) in English, and click here for full [Prescribing Information](#) in Spanish.

5. PRESCRIBER INFORMATION

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

6. PRESCRIPTION FOR AVMAPKI FAKZYNJA CO-PACK (avutometinib capsules; defactinib tablets)
AVMAPKI FAKZYNJA CO-PACK
Rx

 AVMAPKI (avutometinib) dispense quantity:
 0.8-mg capsules, 24-count bottle

 FAKZYNJA (defactinib) dispense quantity: 200-mg tablets,
 42-count bottle

Refills: _____

 STANDARD DOSE
AVMAPKI (avutometinib) 0.8-mg capsules

Take 3.2 mg (4 capsules) by mouth twice weekly (on Day 1 and Day 4) for the first 3 weeks of each 4-week cycle until disease progression or unacceptable toxicity

#24 capsules

FAKZYNJA (defactinib) 200-mg tablets

Take 200 mg (1 tablet) by mouth twice daily for the first 3 weeks of each 4-week cycle until disease progression or unacceptable toxicity

#42 tablets

ALTERNATE DOSE
 AVMAPKI (avutometinib) 0.8-mg capsules

Directions: _____

Quantity (available in 24-count bottle): _____


 FAKZYNJA (defactinib) 200-mg tablets

Directions: _____

Quantity (available in 42-count bottle): _____

Dispense as written, no substitution.

 I authorize Verastem and its agents or contractors to forward the prescription above to a pharmacy within the Verastem Cares Patient Support network.

 Prescriber's Signature: _____
(No Stamps) (Substitution Permitted)

Date: _____

 Prescriber's Signature: _____
(No Stamps) (Dispense as written)

Date: _____

The physician is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription forms, fax language, etc. Noncompliance may result in prescriber outreach.

AVMAPKI FAKZYNJA CO-PACK
Rx
For prescription fulfillment by pharmacy for temporary supply (Quick Start or Bridge)

 AVMAPKI (avutometinib) dispense quantity:
 0.8-mg capsules, 24-count bottle

 FAKZYNJA (defactinib) dispense quantity: 200-mg tablets,
 42-count bottle

Refills: _____

 STANDARD DOSE
AVMAPKI (avutometinib) 0.8-mg capsules

Take 3.2 mg (4 capsules) by mouth twice weekly (on Day 1 and Day 4) for the first 3 weeks of each 4-week cycle until disease progression or unacceptable toxicity

#24 capsules

FAKZYNJA (defactinib) 200-mg tablets

Take 200 mg (1 tablet) by mouth twice daily for the first 3 weeks of each 4-week cycle until disease progression or unacceptable toxicity

#42 tablets

ALTERNATE DOSE
 AVMAPKI (avutometinib) 0.8-mg capsules

Directions: _____

Quantity (available in 24-count bottle): _____


 FAKZYNJA (defactinib) 200-mg tablets

Directions: _____


Quantity (available in 42-count bottle): _____

Dispense as written, no substitution.

 I authorize Verastem and its agents or contractors to forward the prescription above to a pharmacy within the Verastem Cares Patient Support network.

 Prescriber's Signature: _____
(No Stamps) (Substitution Permitted)

Date: _____

 Prescriber's Signature: _____
(No Stamps) (Dispense as written)

Date: _____

The physician is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription forms, fax language, etc. Noncompliance may result in prescriber outreach.



Patient's Name: _____ Patient's Date of Birth: _____

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 AVMAPKI FAKZYNJA CO-PACK (avutometinib capsules; defactinib tablets) 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 Verastem and the Verastem Cares 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 Verastem Cares for AVMAPKI FAKZYNJA CO-PACK support services to my patient, including contacting my patient by telephone, email, or mail for these purposes. I authorize Verastem Cares for AVMAPKI FAKZYNJA CO-PACK to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Verastem products and that I have not received nor will I receive any benefit from Verastem for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by Verastem Cares.

View Privacy Policy: <https://www.verastem.com/privacy-policy/>

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.

7. PREFERRED SPECIALTY PHARMACY

AVMAPKI FAKZYNJA CO-PACK is available through select specialty pharmacies (Onco360, Biologics, and eligible in-office dispensing locations). If your patient's preferred specialty pharmacy is unable to fill for your patient's insurance plan, Verastem Cares can help find a pharmacy to fill.

Patient's Preferred Pharmacy: Onco360 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 AVMAPKI FAKZYNJA CO-PACK already been sent to a pharmacy?

No Yes If "Yes," Date Prescribed: _____ Pharmacy Name: _____

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

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

CONSENTIMIENTO PARA LA INSCRIPCIÓN EN VERASTEM CARES™ Y EL PROGRAMA DE ASISTENCIA AL PACIENTE

Al firmar a continuación, me inscribo en el programa de apoyo al paciente Verastem Cares para AVMAPKI FAKZYNJA CO-PACK (el "Programa"). Autorizo a Verastem y sus filiales, socios comerciales, proveedores y otros agentes (en conjunto, "socios comerciales" y junto con Verastem, "Verastem") a proporcionarme los servicios para los que soy elegible según el Programa. Estos servicios pueden incluir comunicación y apoyo en materia de medicamentos y adherencia al tratamiento, apoyo en la dispensación de medicamentos, cobertura de seguros y asistencia financiera, educación sobre enfermedades y medicamentos, y otros servicios de apoyo que se ofrecen ahora o en el futuro. Como parte de los beneficios del programa, acepto mi inscripción en el programa de asistencia para copagos si cumplo con los requisitos. Si solicito asistencia para pacientes (medicamentos sin costo), autorizo al Programa a utilizar mi información personal para obtener un informe sobre mi historial crediticio individual de agencias de informes de consumidores y utilizar ese informe y otra información recopilada de fuentes públicas y otras fuentes para verificar la información de este formulario y estimar mis ingresos para decidir si soy elegible para medicamentos gratuitos. Previa solicitud, el Programa me proporcionará el nombre y la dirección de la agencia de informes del consumidor que proporciona el informe del consumidor.

Entiendo que los programas de productos gratuitos (Quick Start o Programa de Asistencia al Paciente) están sujetos a criterios de elegibilidad y que completar esta solicitud no garantiza que calificaré para ninguno de estos programas. Certifico que toda la información proporcionada en esta solicitud, incluidos los ingresos familiares, es completa y veraz según mi leal saber y entender. Entiendo que la asistencia del programa finalizará si el Programa o Verastem tienen conocimiento de algún fraude.

Como condición para recibir el producto gratuito bajo este Programa, acepto no solicitar el reembolso del mismo a ninguna aseguradora, plan de salud o programa gubernamental. Si recibo un producto gratuito, no solicitaré que esta receta ni ningún costo asociado se contabilicen como parte de mis gastos de bolsillo para medicamentos recetados.

Si está firmado por un representante del paciente:

Firme aquí: _____ Fecha: _____

Firma del paciente o representante del paciente

Nombre en letra de imprenta

Número de teléfono del representante del paciente

