Verastem Cares™ Enrollment Form

PLEASE COMPLETE THE ENROLLMENT FORM, SIGN, AND FAX IT TO 866-351-0121.

Verastem Cares will acknowledge receipt. For assistance, call Verastem Cares at 866-351-8372.
Verastem Cares is a trademark of Verastem, Inc.
PO Box 5490, Louisville, KY 40255

***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: _____

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 (≥ 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.

VERASTEM

Verastem Cares™ Enrollment Form

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

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.

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: $ _____

CONSENT FOR ENROLLMENT IN VERASTEM CARES™ AND PATIENT ASSISTANCE PROGRAM

By signing below, I am enrolling in Verastem Cares for AVMAPKI FAKZYNJA CO-PACK patient support program (the "Program"). I authorize Verastem and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Verastem, "Verastem") 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 (Quick Start, or Patient Assistance Program) are subject to eligibility criteria and that completing this application does not ensure that I will qualify for any of these programs. I certify that all the information provided in this application, including household income, is complete and accurate to the best of my knowledge. I understand that program assistance will terminate if the Program or Verastem become aware of any fraud.

As a condition of my receiving free product under this Program, I agree that 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 Verastem, and its affiliates, business partners, vendors, and other agents (collectively, "Verastem") 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 AVMAPKI FAKZYNJA CO-PACK (avutometinib capsules; defactinib tablets) (my "Information") to (1) enroll me in and provide services under the Verastem Cares for AVMAPKI FAKZYNJA CO-PACK 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; (5) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Verastem, its support programs, and other Verastem products; and (6) use my de-identified data for research and publication purposes; to conduct data analytics, market research, and Verastem Cares business activities; and/or to contact me about Verastem Cares services. I also understand that Verastem 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 AVMAPKI FAKZYNJA CO-PACK may receive payment from Verastem in exchange for disclosing my de-identified information to Verastem 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 Verastem 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 866-351-8372 or by notifying Verastem 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**