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



855-DAY1-BIO/855-329-1246

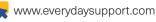


855-332-9663



PATIENT INFORMATION

Monday-Friday 8 Aм-8 РМ ЕТ



### **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.

Instructions for Patients: Please review the Patient Authorization section on pages 3-4 and provide consent in 1 of 3 ways:

- 1. Visit www.everydaysupport.com/consent to provide consent online.
- 2. Review and complete pages 3-4, then email the completed pages to info@everydaysupport.com.
- 3. You and your doctor can complete and submit all 4 pages together in the office.

Patients to complete yellow sections

Prescribers to complete blue sections	)	

Patient First Name:	Patient L	ast Name:		
Date of Birth (DOB):/	_/ Primary Language	: English S	Spanish 🗌 Other: _	
Parent/Legal Guardian Name:	Name: Relationship to Patient:			
Patient Street Address:				
	_ City:			ZIP:
•	ddress:			
	INSURANCE	INFORMATION		
Patient is uninsured				
Please complete all applicable	fields below or attach front ar	nd back copies of	insurance card(s).	
	PRIMARY INSURAN	ICE	PRESCRIPTION	ON 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 1	- itle:	
Office Email Address:				
In-Network Specialty Pharmacy	Preference: Biologics O	nco360 🗌 No pre	eference	EveryDa Sugart

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



			DOB:/
Prescriber First Name:	Prescriber Last I	Name:	NPI #:
	CLINICAL I	NFORMATION	
Primary ICD-10-CM Code(s):		Patient Body Surface	Area (BSA):
Patient Height: Pat	ient Weight:	☐ Ibs ☐ kgs Date o	of Measurement: / /
Allergies:			
	PRESCRIPTION INFORI	MATION AND SIGNAT	URE
OJEMDA  Prescription notes:  It is recommended that patients  For patients with BSA ≥0.90 m² v  Round up or down to nearest tell  For the QuickStart program, the	who require oral suspension, nth decimal place when calc	oral suspension please use "other" line in ulating dosing	n oral suspension section
	COMPLETE BOTH P	RESCRIPTIONS BELOW	
	5 mL, 125 mg) 6 mL, 150 mg) 7 mL, 175 mg) 8 mL, 200 mg) 9 mL, 225 mg) 11 mL, 275 mg) 12 mL, 300 mg) 14 mL, 350 mg) 10 mg once weekly, 4 x 100 mg) 10 mg once weekly, 5 x 100 mg) 10 ce weekly, 6 x 100 mg) 11 mg) 12 mL, 350 mg) 13 mg once weekly, 5 x 100 mg) 14 mg once weekly, 6 x 100 mg) 15 mce weekly	Select formulation for  Oral Suspensio  □ 0.30 m² to 0.  □ 0.43 m² to 0.  □ 0.49 m² to 0.  □ 0.55 m² to 0.  □ 0.64 m² to 0.  □ 0.78 m² to 0.  □ 0.84 m² to 0.  □ 0.84 m² to 0.  □ 0.90 m² to 1.1  □ 1.13 m² to 1.3  □ ≥1.40 m² BSA  □ Other:	on (0.30 m² to 0.89 m² BSA)  .35 m² BSA (5 mL, 125 mg)  .42 m² BSA (6 mL, 150 mg)  .48 m² BSA (7 mL, 175 mg)  .54 m² BSA (8 mL, 200 mg)  .63 m² BSA (9 mL, 225 mg)  .77 m² BSA (11 mL, 275 mg)  .83 m² BSA (12 mL, 300 mg)  .89 m² BSA (14 mL, 350 mg)  m² BSA ( mg)  orally once weekly  m² BSA)  12 m² BSA (400 mg once weekly, 4 x 100 mg)  A (600 mg once weekly, 6 x 100 mg)  m² BSA ( mg)  et(s) orally once weekly  eded for 28 days with PRN (as needed)

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.

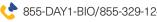
Sign Here

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.

NPI=National Provider Identifier.









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



Patient First Name:	Patient Last Name:	DOB:/
Prescriber First Name:	Prescriber Last Name:	



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").

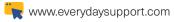
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🕒 Monday–Friday 8 ам–8 рм ET





# **EveryDay Support From Day One**<sup>™</sup> 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.

Patient First N	ame: Patient Last Name:	DOB://
Legal Guardia	n First Name: Legal Guardian Last Name:	
Sign Here	Signature of Patient <u>or</u> Legal Guardian (if patient is under 18 years of age)	//



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