EveryDay Support From Day One™
Enrollment Form

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 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

PATIENT INFORMATION

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 #: ______________________

INSURANCE INFORMATION

☐ Patient is uninsured

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

	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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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: ________ Patient Weight: ________ ☐ lbs ☐ kgs Date of Measurement: ____ /____ /____

Allergies: ____________

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
- Round up or down to nearest tenth decimal place when calculating dosing
- For the QuickStart program, the patient has a diagnosis consistent with the FDA-approved indication

COMPLETE BOTH PRESCRIPTIONS BELOW

PRESCRIPTION

Select formulation for OJEMDA:

Oral Suspension (0.30 m² to 0.89 m² BSA)

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

SIG: Take ______ mL orally once weekly

Tablets (≥0.90 m² BSA)

- ☐ 0.90 m² to 1.12 m² BSA (400 mg once weekly, 4 x 100 mg)
- ☐ 1.13 m² to 1.39 m² BSA (500 mg once weekly, 5 x 100 mg)
- ☐ ≥1.40 m² BSA (600 mg once weekly, 6 x 100 mg)
- ☐ Other: ________ m² BSA (________ mg)

SIG: Take ______ tablet(s) orally once weekly

Dispense quantity needed for 28 days with ______ refills

PRESCRIPTION FOR QUICKSTART PROGRAM

Select formulation for OJEMDA:

Oral Suspension (0.30 m² to 0.89 m² BSA)

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

SIG: Take ______ mL orally once weekly

Tablets (≥0.90 m² BSA)

- ☐ 0.90 m² to 1.12 m² BSA (400 mg once weekly, 4 x 100 mg)
- ☐ 1.13 m² to 1.39 m² BSA (500 mg once weekly, 5 x 100 mg)
- ☐ ≥1.40 m² BSA (600 mg once weekly, 6 x 100 mg)
- ☐ Other: ________ m² BSA (________ mg)

SIG: Take ______ tablet(s) orally once weekly

Dispense quantity needed for 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.

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.

Day One BIOPHARMACEUTICALS

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").

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.

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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