How to Complete the ChimerixCares™ Enrollment Form

Go to **ChimerixCares.com** to enroll patients through the provider portal or to download this form.

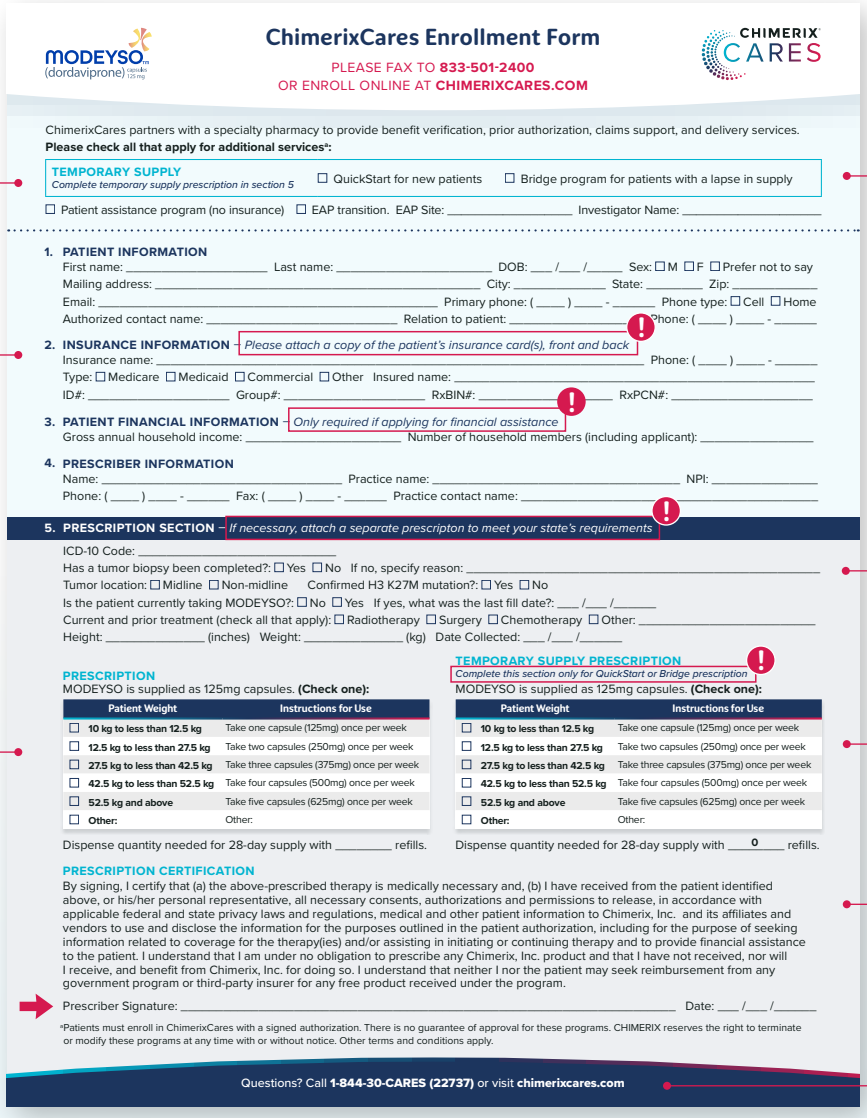
Clinical trial patients were enrolled in the expanded access program (EAP) before the FDA approved Modeyso.

1. PATIENT INFORMATION
Enter all patient information. For patients under 18 years of age, parent or legal guardian name and phone number are required.

2. INSURANCE INFORMATION
If there is additional insurance information, include that on a separate sheet.

3. FINANCIAL INFORMATION
This information is used to understand if the patient may be eligible for financial assistance and may be verified using a third-party financial screening tool.

4. PRESCRIBER INFORMATION
Fill in the prescriber and practice information.



MODEYSO (dordaviprone) 125 mg

ChimerixCares Enrollment Form

PLEASE FAX TO **833-501-2400**
OR ENROLL ONLINE AT **CHIMERIXCARES.COM**

CHIMERIX CARES

ChimerixCares partners with a specialty pharmacy to provide benefit verification, prior authorization, claims support, and delivery services.
Please check all that apply for additional services[a]:

TEMPORARY SUPPLY *Complete temporary supply prescription in section 5* ☐ QuickStart for new patients ☐ Bridge program for patients with a lapse in supply

☐ Patient assistance program (no insurance) ☐ EAP transition. EAP Site: _____ Investigator Name: _____

1. PATIENT INFORMATION
First name: _____ Last name: _____ DOB: ___/___/_____ Sex: ☐M ☐F ☐Prefer not to say
Mailing address: _____ City: _____ State: _____ Zip: _____
Email: _____ Primary phone: (____) ____-_____ Phone type: ☐Cell ☐Home
Authorized contact name: _____ Relation to patient: _____ Phone: (____) ____-_____

2. INSURANCE INFORMATION – *Please attach a copy of the patient's insurance card(s), front and back*
Insurance name: _____ Phone: (____) ____-_____
Type: ☐Medicare ☐Medicaid ☐Commercial ☐Other Insured name: _____
ID#: _____ Group#: _____ RxBIN#: _____ RxPCN#: _____

3. PATIENT FINANCIAL INFORMATION – *Only required if applying for financial assistance*
Gross annual household income: _____ Number of household members (including applicant): _____

4. PRESCRIBER INFORMATION
Name: _____ Practice name: _____ NPI: _____
Phone: (____) ____-_____ Fax: (____) ____-_____ Practice contact name: _____

5. PRESCRIPTION SECTION – *If necessary, attach a separate prescripton to meet your state's requirements*
ICD-10 Code: _____
Has a tumor biopsy been completed?: ☐Yes ☐No If no, specify reason: _____
Tumor location: ☐Midline ☐Non-midline Confirmed H3 K27M mutation?: ☐Yes ☐No
Is the patient currently taking MODEYSO?: ☐No ☐Yes If yes, what was the last fill date?: ___/___/_____
Current and prior treatment (check all that apply): ☐Radiotherapy ☐Surgery ☐Chemotherapy ☐Other: _____
Height: _____ (inches) Weight: _____ (kg) Date Collected: ___/___/_____

PRESCRIPTION
MODEYSO is supplied as 125mg capsules. **(Check one):**

Patient Weight	Instructions for Use
☐ 10 kg to less than 12.5 kg	Take one capsule (125mg) once per week
☐ 12.5 kg to less than 27.5 kg	Take two capsules (250mg) once per week
☐ 27.5 kg to less than 42.5 kg	Take three capsules (375mg) once per week
☐ 42.5 kg to less than 52.5 kg	Take four capsules (500mg) once per week
☐ 52.5 kg and above	Take five capsules (625mg) once per week
☐ Other:	Other:

Dispense quantity needed for 28-day supply with _____ refills.

TEMPORARY SUPPLY PRESCRIPTION
Complete this section only for QuickStart or Bridge prescription
MODEYSO is supplied as 125mg capsules. **(Check one):**

Patient Weight	Instructions for Use
☐ 10 kg to less than 12.5 kg	Take one capsule (125mg) once per week
☐ 12.5 kg to less than 27.5 kg	Take two capsules (250mg) once per week
☐ 27.5 kg to less than 42.5 kg	Take three capsules (375mg) once per week
☐ 42.5 kg to less than 52.5 kg	Take four capsules (500mg) once per week
☐ 52.5 kg and above	Take five capsules (625mg) once per week
☐ Other:	Other:

Dispense quantity needed for 28-day supply with 0 refills.

PRESCRIPTION CERTIFICATION
By signing, I certify that (a) the above-prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, all necessary consents, authorizations and permissions to release, in accordance with applicable federal and state privacy laws and regulations, medical and other patient information to Chimerix, Inc. and its affiliates and vendors to use and disclose the information for the purposes outlined in the patient authorization, including for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy and to provide financial assistance to the patient. I understand that I am under no obligation to prescribe any Chimerix, Inc. product and that I have not received, nor will I receive, and benefit from Chimerix, Inc. for doing so. I understand that neither I nor the patient may seek reimbursement from any government program or third-party insurer for any free product received under the program.

Prescriber Signature: _____ Date: ___/___/_____

[a]Patients must enroll in ChimerixCares with a signed authorization. There is no guarantee of approval for these programs. CHIMERIX reserves the right to terminate or modify these programs at any time with or without notice. Other terms and conditions apply.

Questions? Call **1-844-30-CARES (22737)** or visit **chimerixcares.com**

Select the appropriate prescription strength for your patient based on weight. Be sure to select the quantity of refills needed.

All patients will be screened for each program. However, it's helpful to know which program is being applied for.

Fill out this section with medical information relative to the prescription.

If a temporary supply prescription is needed, fill out this section based on the patient's weight.

Complete the form by signing and dating.

ChimerixCares is here to help. More resources can be found online, and the helpline is open Monday-Friday, 8AM-8PM ET, to answer any of your questions.

CHIMERIX CARES™

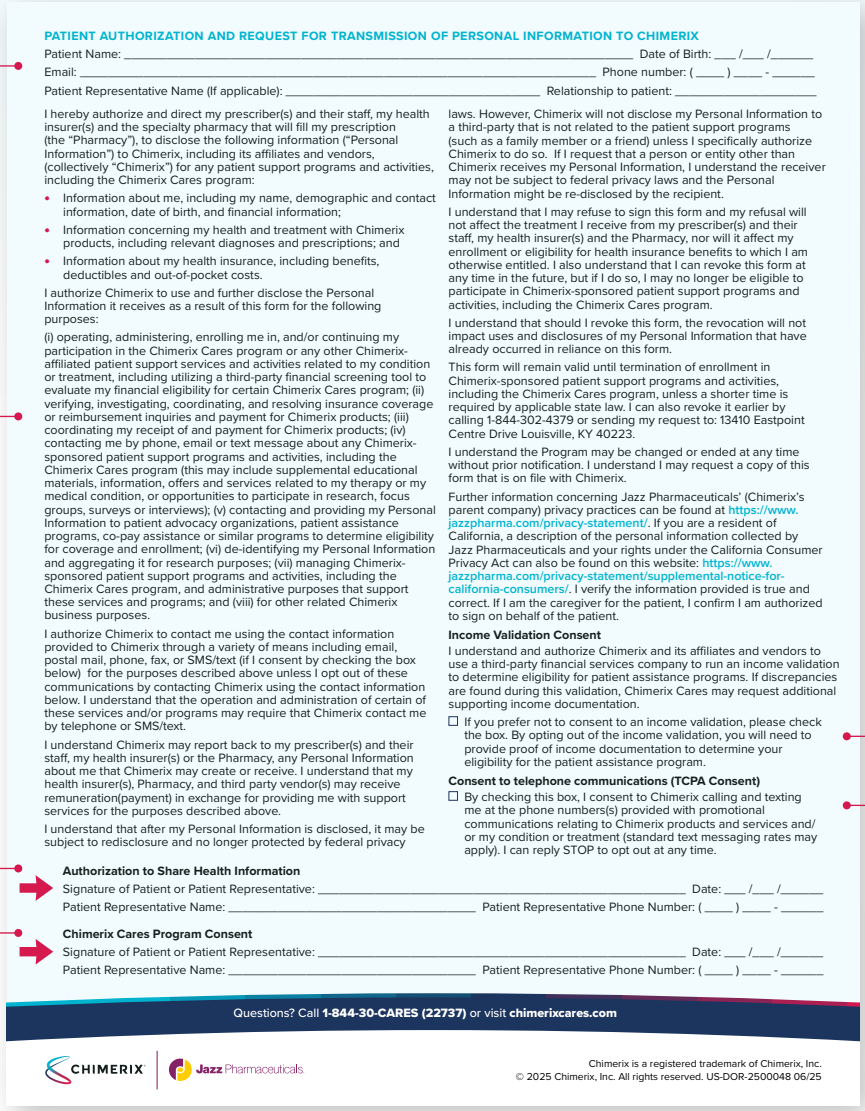
CHIMERIX CARES

Complete the top portion of this page with the patient's information.

The patient or their representative reads through the full authorization statements.

The patient or their representative signs and dates to authorize Chimerix, Inc. and its affiliates to share their health information.

The patient or their representative signs to consent to the ChimerixCares program enrollment.



PATIENT AUTHORIZATION AND REQUEST FOR TRANSMISSION OF PERSONAL INFORMATION TO CHIMERIX

Patient Name: _____ Date of Birth: ___ /___ /_____

Email: _____ Phone number: (____) ____ - _____

Patient Representative Name (If applicable): _____ Relationship to patient: _____

I hereby authorize and direct my prescriber(s) and their staff, my health insurer(s) and the specialty pharmacy that will fill my prescription (the "Pharmacy"), to disclose the following information ("Personal Information") to Chimerix, including its affiliates and vendors, (collectively "Chimerix") for any patient support programs and activities, including the Chimerix Cares program:

- Information about me, including my name, demographic and contact information, date of birth, and financial information;
- Information concerning my health and treatment with Chimerix products, including relevant diagnoses and prescriptions; and
- Information about my health insurance, including benefits, deductibles and out-of-pocket costs.

I authorize Chimerix to use and further disclose the Personal Information it receives as a result of this form for the following purposes:

(i) operating, administering, enrolling me in, and/or continuing my participation in the Chimerix Cares program or any other Chimerix-affiliated patient support services and activities related to my condition or treatment, including utilizing a third-party financial screening tool to evaluate my financial eligibility for certain Chimerix Cares program; (ii) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Chimerix products; (iii) coordinating my receipt of and payment for Chimerix products; (iv) contacting me by phone, email or text message about any Chimerix-sponsored patient support programs and activities, including the Chimerix Cares program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in research, focus groups, surveys or interviews); (v) contacting and providing my Personal Information to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment; (vi) de-identifying my Personal Information and aggregating it for research purposes; (vii) managing Chimerix-sponsored patient support programs and activities, including the Chimerix Cares program, and administrative purposes that support these services and programs; and (viii) for other related Chimerix business purposes.

I authorize Chimerix to contact me using the contact information provided to Chimerix through a variety of means including email, postal mail, phone, fax, or SMS/text (if I consent by checking the box below) for the purposes described above unless I opt out of these communications by contacting Chimerix using the contact information below. I understand that the operation and administration of certain of these services and/or programs may require that Chimerix contact me by telephone or SMS/text.

I understand Chimerix may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Personal Information about me that Chimerix may create or receive. I understand that my health insurer(s), Pharmacy, and third party vendor(s) may receive remuneration(payment) in exchange for providing me with support services for the purposes described above.

I understand that after my Personal Information is disclosed, it may be subject to redisclosure and no longer protected by federal privacy laws. However, Chimerix will not disclose my Personal Information to a third-party that is not related to the patient support programs (such as a family member or a friend) unless I specifically authorize Chimerix to do so. If I request that a person or entity other than Chimerix receives my Personal Information, I understand the receiver may not be subject to federal privacy laws and the Personal Information might be re-disclosed by the recipient.

I understand that I may refuse to sign this form and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, my health insurer(s) and the Pharmacy, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. I also understand that I can revoke this form at any time in the future, but if I do so, I may no longer be eligible to participate in Chimerix-sponsored patient support programs and activities, including the Chimerix Cares program.

I understand that should I revoke this form, the revocation will not impact uses and disclosures of my Personal Information that have already occurred in reliance on this form.

This form will remain valid until termination of enrollment in Chimerix-sponsored patient support programs and activities, including the Chimerix Cares program, unless a shorter time is required by applicable state law. I can also revoke it earlier by calling 1-844-302-4379 or sending my request to: 13410 Eastpoint Centre Drive Louisville, KY 40223.

I understand the Program may be changed or ended at any time without prior notification. I understand I may request a copy of this form that is on file with Chimerix.

Further information concerning Jazz Pharmaceuticals' (Chimerix's parent company) privacy practices can be found at https://www.jazzpharma.com/privacy-statement/. If you are a resident of California, a description of the personal information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found on this website: https://www.jazzpharma.com/privacy-statement/supplemental-notice-for-california-consumers/. I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Income Validation Consent

I understand and authorize Chimerix and its affiliates and vendors to use a third-party financial services company to run an income validation to determine eligibility for patient assistance programs. If discrepancies are found during this validation, Chimerix Cares may request additional supporting income documentation.

☐ If you prefer not to consent to an income validation, please check the box. By opting out of the income validation, you will need to provide proof of income documentation to determine your eligibility for the patient assistance program.

Consent to telephone communications (TCPA Consent)

☐ By checking this box, I consent to Chimerix calling and texting me at the phone numbers(s) provided with promotional communications relating to Chimerix products and services and/or my condition or treatment (standard text messaging rates may apply). I can reply STOP to opt out at any time.

Authorization to Share Health Information

Signature of Patient or Patient Representative: _____ Date: ___ /___ /_____

Patient Representative Name: _____ Patient Representative Phone Number: (____) ____ - _____

Chimerix Cares Program Consent

Signature of Patient or Patient Representative: _____ Date: ___ /___ /_____

Patient Representative Name: _____ Patient Representative Phone Number: (____) ____ - _____

Questions? Call **1-844-30-CARES (22737)** or visit **chimerixcares.com**

CHIMERIX | Jazz Pharmaceuticals

The patient or their representative should only check this box if they are opting out of income validation by Chimerix, Inc and its affiliates. If they check this box, they will still need to provide proof of income for program eligibility.

Patients or their representative check this box to consent to being contacted via the telephone number provided.

Patients can also read and sign this consent online at **ChimerixCares.com**

CHIMERIX | Jazz Pharmaceuticals

MODEYSO™ (dordaviprone) capsules 125 mg

ChimerixCares Enrollment Form

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OR ENROLL ONLINE AT **CHIMERIXCARES.COM**

CHIMERIX® CARES

ChimerixCares partners with a specialty pharmacy to provide benefit verification, prior authorization, claims support, and delivery services.

Please check all that apply for additional services[a]:

TEMPORARY SUPPLY
Complete temporary supply prescription in section 5
☐ QuickStart for new patients ☐ Bridge program for patients with a lapse in supply

☐ Patient assistance program (no insurance) ☐ EAP transition. EAP Site: _____ Investigator Name: _____

1. PATIENT INFORMATION

First name: _____ Last name: _____ DOB: ___ /___ /_____ Sex: ☐ M ☐ F ☐ Prefer not to say
Mailing address: _____ City: _____ State: _____ Zip: _____
Email: _____ Primary phone: (____) ____ - _____ Phone type: ☐ Cell ☐ Home
Authorized contact name: _____ Relation to patient: _____ Phone: (____) ____ - _____

2. INSURANCE INFORMATION – *Please attach a copy of the patient's insurance card(s), front and back*

Insurance name: _____ Phone: (____) ____ - _____
Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Insured name: _____
ID#: _____ Group#: _____ RxBIN#: _____ RxPCN#: _____

3. PATIENT FINANCIAL INFORMATION – *Only required if applying for financial assistance*

Gross annual household income: _____ Number of household members (including applicant): _____

4. PRESCRIBER INFORMATION

Name: _____ Practice name: _____ NPI: _____
Phone: (____) ____ - _____ Fax: (____) ____ - _____ Practice contact name: _____

5. PRESCRIPTION SECTION – *If necessary, attach a separate prescripton to meet your state's requirements*

ICD-10 Code: _____
Has a tumor biopsy been completed?: ☐ Yes ☐ No If no, specify reason: _____
Tumor location: ☐ Midline ☐ Non-midline Confirmed H3 K27M mutation?: ☐ Yes ☐ No
Is the patient currently taking MODEYSO?: ☐ No ☐ Yes If yes, what was the last fill date?: ___ /___ /_____
Current and prior treatment (check all that apply): ☐ Radiotherapy ☐ Surgery ☐ Chemotherapy ☐ Other: _____
Height: _____ (inches) Weight: _____ (kg) Date Collected: ___ /___ /_____

PRESCRIPTION

MODEYSO is supplied as 125mg capsules. **(Check one):**

Patient Weight	Instructions for Use
☐ **10 kg to less than 12.5 kg**	Take one capsule (125mg) once per week
☐ **12.5 kg to less than 27.5 kg**	Take two capsules (250mg) once per week
☐ **27.5 kg to less than 42.5 kg**	Take three capsules (375mg) once per week
☐ **42.5 kg to less than 52.5 kg**	Take four capsules (500mg) once per week
☐ **52.5 kg and above**	Take five capsules (625mg) once per week
☐ **Other:**	Other:

Dispense quantity needed for 28-day supply with _____ refills.

TEMPORARY SUPPLY PRESCRIPTION

Complete this section only for QuickStart or Bridge prescription

MODEYSO is supplied as 125mg capsules. **(Check one):**

Patient Weight	Instructions for Use
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☐ **Other:**	Other:

Dispense quantity needed for 28-day supply with **0** refills.

PRESCRIPTION CERTIFICATION

By signing, I certify that (a) the above-prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, all necessary consents, authorizations and permissions to release, in accordance with applicable federal and state privacy laws and regulations, medical and other patient information to Chimerix, Inc. and its affiliates and vendors to use and disclose the information for the purposes outlined in the patient authorization, including for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy and to provide financial assistance to the patient. I understand that I am under no obligation to prescribe any Chimerix, Inc. product and that I have not received, nor will I receive, and benefit from Chimerix, Inc. for doing so. I understand that neither I nor the patient may seek reimbursement from any government program or third-party insurer for any free product received under the program.

Prescriber Signature: _____ Date: ___ /___ /_____

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Email: _____ Phone number: (____) ____ - _____

Patient Representative Name (If applicable): _____ Relationship to patient: _____

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- Information about me, including my name, demographic and contact information, date of birth, and financial information;
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I understand Chimerix may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Personal Information about me that Chimerix may create or receive. I understand that my health insurer(s), Pharmacy, and third party vendor(s) may receive remuneration(payment) in exchange for providing me with support services for the purposes described above.

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Authorization to Share Health Information

Signature of Patient or Patient Representative: _____ Date: ___ /___ /_____

Patient Representative Name: _____ Patient Representative Phone Number: (____) ____ - _____

Chimerix Cares Program Consent

Signature of Patient or Patient Representative: _____ Date: ___ /___ /_____

Patient Representative Name: _____ Patient Representative Phone Number: (____) ____ - _____