CHIMERIX CARES™

Navigating Patient Support for MODEYSO™ (dordaviprone) with ChimerixCares™

RESOURCE NAVIGATION GUIDE

This document serves as a comprehensive guide to ChimerixCares, a patient support program designed to assist patients prescribed MODEYSO™ (dordaviprone).

This guide details **how to enroll** patients in ChimerixCares and outlines the program's **services**, including support for navigating insurance processes and assessing eligibility for our financial assistance programs (e.g., Copay Assistance Program, Patient Assistance Program, Temporary Supply Program). It outlines how ChimerixCares **helps coordinate medication home delivery** with a specialty pharmacy and also provides essential **product and distribution information** for MODEYSO. Finally, you'll find **descriptions of the tools and templates** ChimerixCares makes available to healthcare providers to manage prior authorization and appeals processes.

Contact ChimerixCares: You can call us at 1-844-30-CARES (22737).
We're available Monday-Friday, 8 AM-8 PM ET.

Table of Contents

About ChimerixCares™

ChimerixCares was developed to make it as easy as possible for patients prescribed MODEYSO™ (dordaviprone) to start and stay on their medication. To access ChimerixCares service offerings, patients must enroll in the program.

Three Ways to Enroll in ChimerixCares and Receive MODEYSO

Enroll online by going to **ChimerixCares.com** and clicking on "Provider Portal"

OR

e-Prescribe at Onco360

Phone: 1-877-662-6633

Fax: 1-877-662-6355

ePrescribe: OncoMed dba Onco360 or NPI#1679618151

OR

Download the enrollment form at **Chimerixcares.com**, complete it, and follow the instructions to fax it

Once patients are enrolled, ChimerixCares coordinates with the specialty pharmacy (Onco360) for MODEYSO home delivery and continued support. Onco360 will ship MODEYSO directly to your patient and afterward will follow up with refill reminders and adherence support.

Your Support Team

Care Coordinators

A Care Coordinator will work with each patient to understand their unique situation and assess their eligibility for additional ChimerixCares™ support offerings. Additionally, Care Coordinators...

- Are available by phone from 8AM to 8PM ET Monday through Friday
- Serve as the main point of contact for the patient
- Review eligibility for program offerings, including the Copay Assistance Program, the Temporary Supply Program, and the Patient Assistance Program

Specialty Pharmacy

ChimerixCares will partner with you and the specialty pharmacy to help navigate the insurance process.

Onco360 is the specialty pharmacy responsible for shipping MODEYSO™ (dordaviprone) directly to patients. Other services include:

- Completing a benefit investigation to understand your patients' coverage and out-of-pocket costs
- Helping support the prior authorization (PA) process
- Assisting in understanding and supporting the appeals process if the insurance company denies coverage
- Helping determine eligibility for the Temporary Supply Program
- Following up with refill reminders and additional support once the patient is on therapy and throughout their treatment journey

The Field Access Navigation (FAN) Team

The FAN team provides expert understanding of regional and local access landscapes. The FAN team:

- Serves as the key field contact for healthcare providers who need additional information on MODEYSO access and available support services
- Works directly with the healthcare provider, specialty pharmacy, and others to proactively identify and support through complex patient access issues, (e.g., prior authorizations, appeals, denials, letters of medical necessity)

Financial Assistance Programs

CHIMERIX CARES™

For more information on patient financial assistance and for complete eligibility information, contact ChimerixCares™ at 1-844-302-2737.

Copay Assistance Program

Eligible patients with commercial insurance may pay **as little as** **$0** out of pocket for their prescription.

Patient Assistance Program

Patients who are uninsured or underinsured and meet certain financial criteria **may be eligible to receive MODEYSO™ (dordaviprone)** **at no cost.**

Temporary Supply Program

If your patient experiences a delay in insurance approval or an interruption or gap in insurance coverage, they may be eligible for a **temporary no-cost supply of MODEYSO** to help start or continue treatment.

Prior Authorization Checklist

This comprehensive checklist is designed to help your office gather all necessary information for MODEYSO™ (dordaviprone) that the insurance company may request for PA submissions.

A. Patient Information

- ☐ **Patient name**
- ☐ **Date of birth**
- ☐ **Patient phone number**
- ☐ **Patient address**
- ☐ **Insurance carrier**
- ☐ **Member ID / Policy number**
- ☐ **Group number** (if applicable)
- ☐ **Insurance phone number** (for provider use)
- ☐ **Insurance fax number** (for provider use)
- ☐ **Subscriber name** (if different from patient)
- ☐ **Relationship to subscriber**

B. Provider Information

- ☐ **Referring provider name**
- ☐ **Referring provider NPI**
- ☐ **Referring provider phone number**
- ☐ **Referring provider fax number**
- ☐ **Servicing provider/Facility name** (if different)
- ☐ **Servicing provider/Facility phone number**
- ☐ **Servicing provider/Facility fax number**

C. Service/Medication Information

- ☐ **Type of service/Item**: Medication (prescription drug)
- ☐ **Specific request**: MODEYSO (dordaviprone)
- ☐ **ICD-10 Code(s)** (diagnosis):
- ☐ **Medication name** (with strength and dosage): MODEYSO (dordaviprone) 125 mg capsules, [dosage]
- ☐ **Anticipated date of service/Start date**:
- ☐ **Frequency/Duration of service** (e.g., duration of medication refill):

Prior Authorization Checklist (cont.)

D. Clinical Documentation & Justification

- ☐ **Clinical notes/Progress notes** (e.g., date of latest relevant visit, history of present illness (HPI), relevant past medical history, current symptoms and their severity, physical exam findings (if applicable))
- ☐ **Relevant test results/Imaging reports** (e.g., lab results, MRI reports, pathology reports)
- ☐ **Treatment history** (e.g., therapies that have been tried and failed (list-specific drug names, dates, dosages, and responses/reasons for failure), dates of previous treatments, reason for failure/inadequacy of previous treatments, contraindications to alternative treatments)
- ☐ **Rationale for current request:** Why is MODEYSO™ (dordaviprone) medically appropriate for this patient?

E. Submission Process

- ☐ **Verify payer requirements.** Is prior authorization (PA) required for this service/patient/plan? What is the preferred submission method (online portal, fax, phone)? Does the payer require specific forms? What is the typical turnaround time for this payer?
- ☐ **Compile all required documentation**
  - ☐ **Submission date**
  - ☐ **Confirmation number/Tracking ID** (if provided by payer)
  - ☐ **Contact person at payer** (if applicable during phone submission)
  - ☐ **Notes on submission** (e.g., issues encountered, specific instructions given)

F. Follow-Up & Resolution

- ☐ **Expected decision date**
- ☐ **Follow-up date(s) scheduled**
- ☐ **Authorization status**: Approved, Denied, Pending, Additional Information Requested (and date requested)
- ☐ **Authorization number** (if approved)
- ☐ **Effective dates of authorization**
- ☐ **Number of units/visits/refills authorized**
- ☐ **Reason for denial** (if denied)
- ☐ **Next steps for denial** (appeal process initiated (date), peer-to-peer review requested (date), alternative treatment plan considered)
- ☐ **Communication with patient** (date patient was informed of authorization status, patient understands next steps)

Sample Letters of Support

ChimerixCares™ offers customizable templated letters to help healthcare providers prepare required documentation for MODEYSO™ (dordaviprone) coverage. Each letter requires description of medical rationale and rationale for prescribing of MODEYSO:

Describe medical rationale

Clearly articulate why MODEYSO is the most appropriate treatment for this patient.

- Given [Patient Name]'s specific [diagnosis] confirmed by [specify diagnostic method, e.g., biopsy and molecular testing], and documented treatment history [list specific prior therapies], MODEYSO is an appropriate treatment.
- [Explain how MODEYSO's mechanism of action (if known/relevant to the payer) specifically addresses this patient's disease, offering a unique therapeutic approach where prior broad-spectrum treatments have failed.]
- [Discuss the potential for MODEYSO to improve outcomes, stabilize disease, or alleviate symptoms based on its clinical profile.]
- [Mention any contraindications or intolerances to alternative treatments that further support MODEYSO as the optimal choice.]

Provide rationale for prescribing MODEYSO

My rationale for prescribing MODEYSO is based on [include a brief disease course of patient, including history of disease, key laboratory results, current symptoms, and comprehensive previous treatments (including names, dosages, frequency, and length). If the patient has discontinued treatment, please include information on the reasons for such discontinuation (e.g., disease progression, lack of efficacy, adverse events). You may also want to include medical reasoning for choosing to bypass any alternative medications preferred by the health plan, such as reasons for non-compliance with other therapies, or any relevant treatment guidelines that support the use of MODEYSO.]

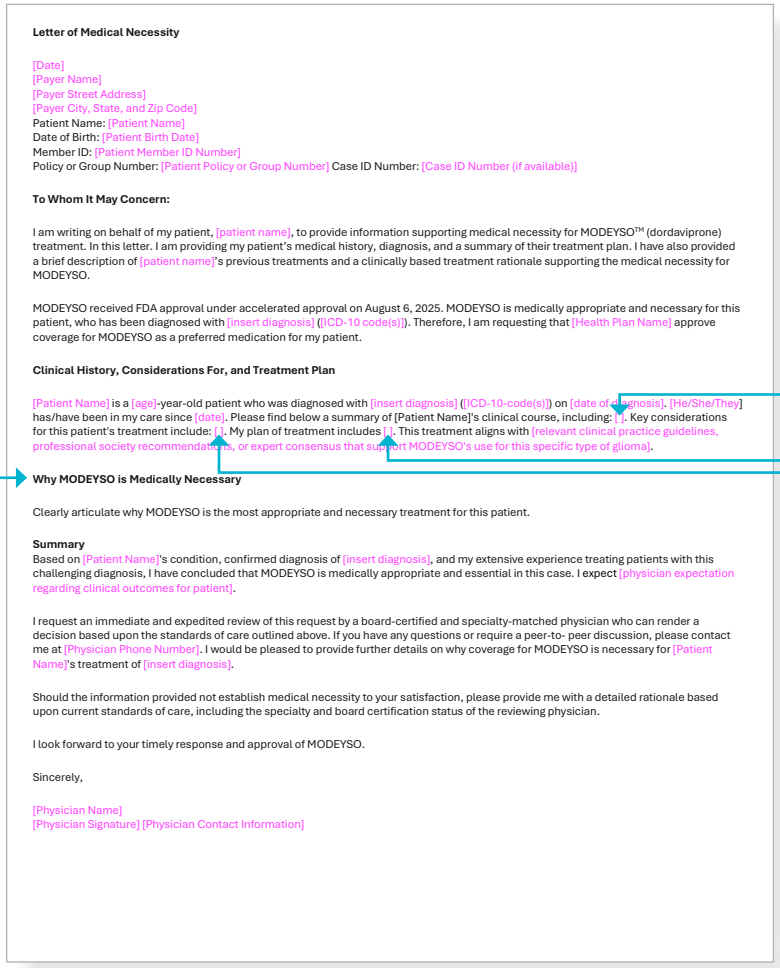
[Please exercise your medical judgment and discretion when providing diagnosis and characterization of the patient's medical condition.]

For further assistance, please contact ChimerixCares Patient Support Program at 1-844-30-CARES (22737) or visit ChimerixCares.com.

Please Note: The use of these templates does not guarantee approval or reimbursement for MODEYSO. These templates are not intended to replace or influence the independent medical judgment of the healthcare provider.

Sample Letters of Support (cont.)

Letter of Medical Necessity Template



Letter of Medical Necessity

[Date]
[Payer Name]
[Payer Street Address]
[Payer City, State, and Zip Code]
Patient Name: [Patient Name]
Date of Birth: [Patient Birth Date]
Member ID: [Patient Member ID Number]
Policy or Group Number: [Patient Policy or Group Number] Case ID Number: [Case ID Number (if available)]

To Whom It May Concern:

I am writing on behalf of my patient, [patient name], to provide information supporting medical necessity for MODEYSO™ (dordaviprone) treatment. In this letter. I am providing my patient's medical history, diagnosis, and a summary of their treatment plan. I have also provided a brief description of [patient name]'s previous treatments and a clinically based treatment rationale supporting the medical necessity for MODEYSO.

MODEYSO received FDA approval under accelerated approval on August 6, 2025. MODEYSO is medically appropriate and necessary for this patient, who has been diagnosed with [insert diagnosis] ([ICD-10 code(s)]). Therefore, I am requesting that [Health Plan Name] approve coverage for MODEYSO as a preferred medication for my patient.

Clinical History, Considerations For, and Treatment Plan

[Patient Name] is a [age]-year-old patient who was diagnosed with [insert diagnosis] ([ICD-10-code(s)]) on [date of diagnosis]. [He/She/They] has/have been in my care since [date]. Please find below a summary of [Patient Name]'s clinical course, including: [ ]. Key considerations for this patient's treatment include: [ ]. My plan of treatment includes [ ]. This treatment aligns with [relevant clinical practice guidelines, professional society recommendations, or expert consensus that support MODEYSO's use for this specific type of glioma].

Why MODEYSO is Medically Necessary

Clearly articulate why MODEYSO is the most appropriate and necessary treatment for this patient.

Summary
Based on [Patient Name]'s condition, confirmed diagnosis of [insert diagnosis], and my extensive experience treating patients with this challenging diagnosis, I have concluded that MODEYSO is medically appropriate and essential in this case. I expect [physician expectation regarding clinical outcomes for patient].

I request an immediate and expedited review of this request by a board-certified and specialty-matched physician who can render a decision based upon the standards of care outlined above. If you have any questions or require a peer-to- peer discussion, please contact me at [Physician Phone Number]. I would be pleased to provide further details on why coverage for MODEYSO is necessary for [Patient Name]'s treatment of [insert diagnosis].

Should the information provided not establish medical necessity to your satisfaction, please provide me with a detailed rationale based upon current standards of care, including the specialty and board certification status of the reviewing physician.

I look forward to your timely response and approval of MODEYSO.

Sincerely,

[Physician Name]
[Physician Signature] [Physician Contact Information]

This template helps demonstrate the medical necessity of MODEYSO.

If sending by email, use a clear and direct subject line, such as:
Action Required: Letter of Medical Necessity – Coverage Request for MODEYSO (dordaviprone) [125 mg] Capsules for [Patient Name]

- Treatment history
- Relevant history
- Laboratory results including molecular testing for key biomarkers
- Imaging findings
- Symptoms
- Previous treatments

- Previous treatments
  - Drug name
  - Start date
  - Stop date
  - Reasons for discontinuing
- Complications
- Treatment plan

- Dosage
- Frequency
- Estimated length of treatment (e.g., “125 mg orally once daily, continuously as tolerated and until disease progression”)

- Improved symptoms
- Disease stabilization
- Prevention of progression
- Improved quality of life

When submitting this letter, we recommend attaching the following:

- ☐ **MODEYSO™ (dordaviprone) Prescribing Information** (Package Insert)
- ☐ **Medical records and relevant clinical notes**
- ☐ **Lab results including molecular testing for key biomarkers**
- ☐ **Imaging reports**
- ☐ **Any other supplementary supporting documents**

Sample Letters of Support (cont.)

Appeal Letter Template
Request for Reconsideration

Appeal Letter

[Date]
[Payer Name]
[Payer Street Address]
[Payer City, State, and Zip Code]
Patient Name: [Patient Name]
Date of Birth: [Patient Birth Date]
Member ID: [Patient Member ID Number]
Policy or Group Number: [Patient Policy or Group Number] Case ID Number: [Case ID Number (if available)]

To Whom It May Concern:

My name is [Physician Name], and I am a [board-certified medical specialty] (NPI: [Your NPI]). This letter serves as the [1st/2nd] appeal for approval of MODEYSO™ (dordaviprone), which was originally denied for [Patient Name] on [date of denial]. I am writing to provide additional information to support my request to treat [Patient Name], who has been diagnosed with [insert diagnosis] ([ICD-10 code(s)]), with MODEYSO.

In brief, treating [Patient Name] with MODEYSO is medically appropriate and necessary and should be covered and reimbursed. [Health Plan Name] determined MODEYSO was not covered for [Patient Name] because [clearly state the specific reason(s) for denial provided in the EOB]. This letter provides my clinical rationale and relevant information about the patient's medical history and treatment plan to address the denial.

Clinical History, Considerations For, and Treatment Plan

[Patient Name] is a [age]-year-old patient who was diagnosed with [insert diagnosis] ([ICD-10-code(s)]) on [date of diagnosis]. [He/She/They] has/have been in my care since [date]. Please find below a summary of [Patient Name]'s clinical course, including: [ ]. Key considerations for this patient's treatment include: [ ]. My plan of treatment includes [ ]. This treatment aligns with [relevant clinical practice guidelines, professional society recommendations, or expert consensus that support MODEYSO's use for this specific type of glioma].

Why MODEYSO is Medically Necessary

Clearly articulate why MODEYSO is the most appropriate and necessary treatment for this patient.

Summary
Based on the patient's condition, confirmed diagnosis of [insert diagnosis], prior therapies for [insert indication], and my experience treating patients with this challenging diagnosis, I believe treatment with MODEYSO is warranted, appropriate, and medically necessary in this case. The accompanying package insert provides the approved clinical information for MODEYSO. I have attached relevant lab test analyses, imaging reports, and medical records to support my decision and refute the grounds for the previous denial.

I am requesting an immediate and expedited review of this appeal, along with the enclosed documents and supporting evidence, by my office and by a board-certified and specialty-matched physician who can render a decision based upon the standards of care outlined above. If you have any further questions about this matter, please contact me at [Physician Phone Number], via e-mail at [Physician Email], or by fax at [Provider Fax Number]. I look forward to receiving your timely response and approval of this claim.

Once approved for MODEYSO, I will discontinue the treatment/prescription of [alternate BRAND (generic) name], if applicable.

If you do not feel that the information provided has established medical necessity, please provide me with your detailed rationale based upon current standards of care, the specialty of the physician who reviewed this case, and whether they are board-certified in an applicable medical specialty.

Sincerely,

[Physician Name]
[Physician Signature] [Physician Contact Information]

This template is designed to help healthcare providers appeal denied coverage for MODEYSO.

If sending by email, use a clear and direct subject line, such as:
Action Required: Request for Reconsideration for MODEYSO (dordaviprone) 125 mg Capsules for [Patient Name]

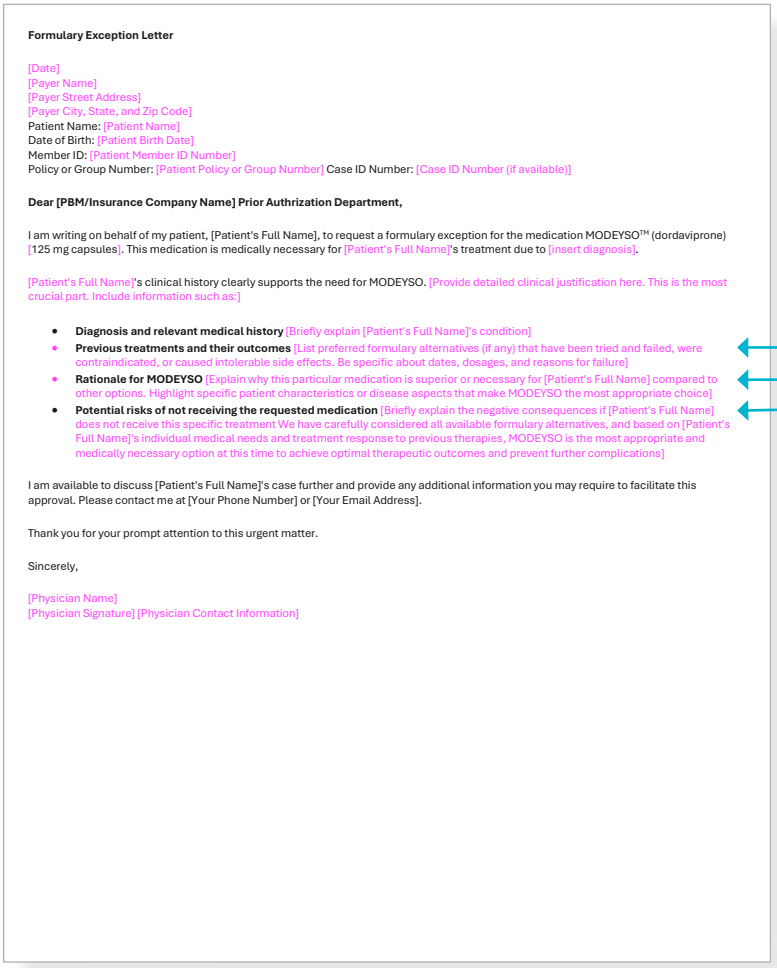
- Unmet need
- Mechanism of action
- Clinical data
- Treatment guidelines
- Discontinuation of previous treatments
- Medical reasoning for bypassing alternative treatments

When submitting this letter, we recommend attaching the following:

- ☐ **Patient medical records/Clinical notes**
- ☐ **MODEYSO™ (dordaviprone) Prescribing Information** (Package Insert)
- ☐ **Original Letter of Medical Necessity** (if applicable)
- ☐ **Copy of Patient Denial Letter/Explanation of Benefits (EOB)**
- ☐ **Clinical progress notes**
- ☐ **Patient's lab results including molecular testing for key biomarkers**
- ☐ **Relevant imaging reports** (e.g., MRI scans showing disease progression or prior treatment effects)
- ☐ **Documentation of hospitalization/Emergency room visits and/or unscheduled office visits** (if applicable)
- ☐ **List of previous medications provided, including dosages, dates used, and reasons for discontinuation** (e.g., lack of efficacy, side effects)
- ☐ **Relevant clinical trial data or publications** (if applicable, for a new product/indication)

Sample Letters of Support (cont.)

Formulary Exception Letter Template



Formulary Exception Letter

[Date]
[Payer Name]
[Payer Street Address]
[Payer City, State, and Zip Code]
Patient Name: [Patient Name]
Date of Birth: [Patient Birth Date]
Member ID: [Patient Member ID Number]
Policy or Group Number: [Patient Policy or Group Number] Case ID Number: [Case ID Number (if available)]

Dear [PBM/Insurance Company Name] Prior Authrization Department,

I am writing on behalf of my patient, [Patient's Full Name], to request a formulary exception for the medication MODEYSO™ (dordaviprone) [125 mg capsules]. This medication is medically necessary for [Patient's Full Name]'s treatment due to [insert diagnosis].

[Patient's Full Name]'s clinical history clearly supports the need for MODEYSO. [Provide detailed clinical justification here. This is the most crucial part. Include information such as:]

- **Diagnosis and relevant medical history** [Briefly explain [Patient's Full Name]'s condition]
- **Previous treatments and their outcomes** [List preferred formulary alternatives (if any) that have been tried and failed, were contraindicated, or caused intolerable side effects. Be specific about dates, dosages, and reasons for failure]
- **Rationale for MODEYSO** [Explain why this particular medication is superior or necessary for [Patient's Full Name] compared to other options. Highlight specific patient characteristics or disease aspects that make MODEYSO the most appropriate choice]
- **Potential risks of not receiving the requested medication** [Briefly explain the negative consequences if [Patient's Full Name] does not receive this specific treatment We have carefully considered all available formulary alternatives, and based on [Patient's Full Name]'s individual medical needs and treatment response to previous therapies, MODEYSO is the most appropriate and medically necessary option at this time to achieve optimal therapeutic outcomes and prevent further complications]

I am available to discuss [Patient's Full Name]'s case further and provide any additional information you may require to facilitate this approval. Please contact me at [Your Phone Number] or [Your Email Address].

Thank you for your prompt attention to this urgent matter.

Sincerely,

[Physician Name]
[Physician Signature] [Physician Contact Information]

This template helps request a formulary exception for MODEYSO™ (dordaviprone).

If sending by email, use a clear and direct subject line, such as:
Formulary Exception Request for MODEYSO (dordaviprone) for [Patient's Full Name] - Patient Date of Birth: [Patient's Date of Birth] - Policy/Member ID: [Patient's Policy/Member ID]

For example: "[Patient's Full Name] previously attempted treatment with [Alternative Drug 1] from [Date] to [Date], which resulted in [specify adverse event or lack of efficacy (e.g., documented disease progression)]. [Alternative Drug 2] was also considered but is contraindicated due to [reason, e.g., hepatic impairment, specific drug interaction]."

For example: "Given [Patient's Full Name]'s unique presentation of [diagnosis], MODEYSO offers the best chance for [desired outcome/response] based on its targeted mechanism of action and efficacy demonstrated in clinical trials for this specific patient population."

- Continued disease progression
- Worsening neurological symptoms
- Reduced quality of life

CHIMERIX CARES™

Contact ChimerixCares™

For any questions regarding patient support services, enrollment, or navigating access for MODEYSO™ (dordaviprone), please contact ChimerixCares directly:

Website

ChimerixCares.com

Phone

1-844-30-CARES (22737)

Hours:
Monday-Friday, 8 AM - 8 PM ET

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