DOSE EXCHANGE FORM

At times, a patient's dose may need to be adjusted during the course of treatment, and in order to facilitate this process, the YourBlueprint™ Dose Exchange Program is available. If your patient meets the requirements outlined in the Program Eligibility section below, they may qualify for this program. Please fax the completed and signed form to YourBlueprint.

Please note that the YourBlueprint Dose Exchange Program is facilitated by the YourBlueprint non-commercial pharmacy and not by the pharmacy to which the patient's previous prescription was submitted. For future refills, a new prescription will need to be submitted to the patient's current dispensing pharmacy.

1. PROGRAM ELIGIBILITY

In order to be eligible to participate in the Dose Exchange Program:

- Prescriber must complete the YourBlueprint Dose Exchange Form
- Patient must reside in the United States or its territories
- Patient must have remaining pills from a current prescription
- Patient must return his or her remaining pills. Instructions for return will be provided with a pre-addressed envelope for the patient to return the unused quantity of previous strength
- Patient must not have already had two (2) separate dose adjustments under the YourBlueprint Dose Exchange Program

2. PATIENT INFORMATION

Patient Name (First, MI, Last):______________________ DOB (MM/DD/YYYY):__________

Patient Phone:__________ Patient Address:______________________

City:______________________ State:__________ ZIP:__________

3. PRESCRIBER INFORMATION

Prescriber Name (First, MI, Last):______________________

Practice Name:______________________ Practice Contact:__________

Practice Address:______________________

City:______________________ State:__________ ZIP:__________

Phone:__________ Fax:__________ NPI #:__________

4. AYVAKIT™ (avapritinib) REPLACEMENT PRESCRIPTION

Current AYVAKIT Dose:

- ○ 100 mg (30 tablets)
- ○ 200 mg (30 tablets)
- ○ 300 mg (30 tablets)

New AYVAKIT Dose (No Refills):

- ○ 100 mg (30 tablets)
- ○ 200 mg (30 tablets)
- ○ 300 mg (30 tablets)

Directions for use: ______________________

SIGN HERE Prescriber's Signature:______________________ Date:__________

Special Note: If a New York prescriber, please use an original New York State prescription form. The prescriber is to comply with the prescriber's state-specific prescription requirements.

5. TERMS AND CONDITIONS

- The Dose Exchange Program is available to a given patient for up to two (2) separate dose adjustments. The quantity to exchange may not exceed 30 tablets per adjustment
- The prescriber, prescriber's institution, and patient will not submit a claim for reimbursement or otherwise seek payment from any source for the dose exchange product, and the dose exchange product will not be returned to Blueprint Medicines™ or its distributor for a refund or credit
- Product provided in this program is intended only for the patient listed on this form. The product provided may not be given to any other patient or distributed elsewhere

I agree to the terms and conditions outlined on this form:

SIGN HERE Prescriber's Signature:______________________ Date:__________

PLEASE FAX COMPLETED AND SIGNED FORM TO 1-866-370-3082

Phone: 1-888-BLUPRNT (1-888-258-7768) Fax: 1-866-370-3082 Monday-Friday 8 AM-8 PM ET www.YourBlueprint.com

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