



PATIENT SUPPORT PROGRAM CONSENT AND HIPAA AUTHORIZATION

Please fill out this form completely, sign and send back both pages via one of the following methods:

- Fax this page to 1-866-370-3082 OR
- Scan / photograph and email this form to info@yourblueprint.com OR
- Mail this form to YourBlueprint™, PO Box 15590, Pittsburgh, PA 15244

For additional assistance, call 1-888-BLUPRNT (1-888-258-7768), Monday-Friday, 8 AM-8 PM Eastern Time (ET)

PATIENT INFORMATION

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

Street Address: _____

City: _____ State: _____ ZIP: _____ Sex: Male Female

Email Address: _____

Primary Phone: _____ Okay to leave voicemail

Alternate Phone: _____ Okay to leave voicemail

Best Time to Contact: Morning Afternoon Evening

Patient Representative / Caregiver: _____

Patient Representative / Caregiver Phone: _____

YOURBLUEPRINT™ FOR AYVAKIT™ (avapritinib) ENROLLMENT CONSENT

Please read the following, and if you agree, sign below.

By signing below, I am enrolling in YourBlueprint for AYVAKIT patient support program (the "Program"). I authorize Blueprint Medicines Corporation and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Blueprint Medicine Corporation, "Blueprint Medicines") to provide me with services for which I am eligible under the Program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to my enrollment in the copay assistance program if I am eligible. If I am applying for patient assistance (no-cost medication) I authorize the Program to use my personal information to obtain a report on my individual credit history from consumer reporting agencies and use that report and other information collected from public and other sources to verify the information on this form and estimate my income to decide if I am eligible for free medication. Upon request, the Program will provide me the name and address of the consumer reporting agency that provides the consumer report.

I understand that Blueprint Medicines Corporation and its business partners may use and share with each other and with my healthcare providers, pharmacies, and health insurance plans, my Information in connection with providing services to me under the Program, administering the Program, or as otherwise required for Blueprint Medicines to meet its legal obligations. I authorize Blueprint Medicines to contact me by mail, telephone, and email with disease information or with information about Blueprint Medicines products, promotions, services, or research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize Blueprint Medicines to de-identify my information and use it in performing research, education, business analytics, and marketing studies or for other commercial purposes.

I understand I do not have to enroll in the Program and that I can still receive AYVAKIT as prescribed by my physician. I understand that I may at any time opt out of individual services offered by the Program or opt out of the Program entirely by notifying a Program representative by calling 1-888-BLUPRNT (1-888-258-7768) or by writing to YourBlueprint at PO Box 15590, Pittsburgh, PA 15244. I understand that the Program may be changed or discontinued in whole or in part by Blueprint Medicines at any time.

By signing below, I certify that I have read the YourBlueprint for AYVAKIT Enrollment Consent and I agree to the terms of enrollment.

SIGN
HERE

x _____

Signature of Patient or Patient Representative _____ Date _____

If signed by a Patient Representative _____

Printed Name _____ Phone Number of Patient Representative _____



Phone: 1-888-BLUPRNT (1-888-258-7768)



Fax: 1-866-370-3082



Monday-Friday 8 AM-8 PM ET



www.YourBlueprint.com



Privacy Authorization and Enrollment Consent

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AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read this page carefully, and if you agree, sign the Agreement to Share Health Information agreement below. You may keep a copy of this form for your records.

I authorize my health care providers and staff, my pharmacies, and my health insurers to use and to disclose to Blueprint Medicines and its affiliates, business partners, vendors, and other agents (collectively, "Blueprint Medicines") health information about me, including information related to my medical condition and treatment, health insurance and coverage claims, and prescription (including fill/refill information) for AYWAKIT (my "Information") for the purpose of enrolling me in and providing services under the YourBlueprint for AYWAKIT patient support program (the "Program"). Once my Information has been disclosed to Blueprint Medicines, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Blueprint Medicines will protect my Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise required by law. I understand and agree that the pharmacy that dispenses my AYWAKIT may receive payment from Blueprint Medicines in exchange for disclosing my Information to Blueprint Medicines.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment from my health care providers, my eligibility for health insurance benefits, or my access to Blueprint Medicines medications. However, if I do not sign this Authorization, I understand I will not be able to participate in the Program. I understand that this Authorization expires ten years from the date signed below, or as otherwise required by state or local law, unless and until I cancel (take back) this Authorization before then. I may change my mind and cancel this Authorization at any time by calling 1-888-BLUPRNT (1-888-258-7768) or by notifying Blueprint Medicines in writing at PO Box 15590, Pittsburgh, PA 15244. Cancellation of this Authorization will end further uses and disclosures of my Information and my participation in the Program but will not affect any uses or disclosure of my Information made by my health care providers and staff, my pharmacies, and my health insurers based on this Authorization before receipt of the cancellation.

I understand I may request a signed copy of this Authorization.

By signing below, I certify that I have read the Authorization to Share Health Information and I authorize the disclosure of my Information to Blueprint Medicines as described.

SIGN HERE

Signature of Patient or Patient Representative	Date
If signed by a Patient Representative	
Printed Name	Phone Number of Patient Representative