Doptelet
(avatrombopag) tablets

DOVA 1SOURCE™ PATIENT ENROLLMENT FORM AND STATEMENT OF MEDICAL NECESSITY

Please sign and fax the completed form and required documentation to Dova 1Source or directly to one of the listed specialty pharmacies. You can also complete enrollment online at dova1source.com. Asterisk indicates required field or section.

Dova 1Source Contact Information

Fax:	855-686-8729
E-mail:	info@Dova1Source.com
Online:	Dova1Source.com
Phone:	833-368-2663

Pharmacy	Phone	Fax
Accredo	877-732-3431	888-302-1028
CVS Specialty	800-284-5071	877-408-9743
Diplomat	877-977-9118	866-376-1448
Kroger Specialty	888-355-4191	888-355-4192
PANTHERx	855-985-0390	412-420-6251
Alliance Walgreens Prime	888-347-3416	877-231-8302

Preferred Pharmacy: Preferred pharmacy will be utilized when allowed by the payer. ❑ Accredo ❑ CVS Specialty ❑ Diplomat ❑ Kroger Specialty ❑ PANTHERx ❑ Alliance Walgreens Prime

1. Patient Information

Patient signature required on the Program Authorization and Consent Form.*

First name* _____ Last name* _____

DOB* *(MM/DD/YYYY)* _____ Gender ❑ M ❑ F Last 4 Digits of SSN* _____

Address* _____ Apt. Number* _____

City* _____ State* _____ ZIP* _____

Preferred contact: Phone* _____ Alternate Phone* _____

❑ **Ship to patient upon approval and completion of Rx** **OR** ❑ **Ship to prescriber's office in Section 3 upon approval and completion of Rx**

2. Patient Insurance Information*

❑ Patient **has** insurance **OR** ❑ Patient **does not** have insurance **If patient has insurance include copies of the front and back of insurance card(s).**

Prescription drug insurer/pharmacy benefit manager *(PBM)* _____

Phone _____ Policy number _____

Rx BIN _____ Rx Group _____ Rx PCN _____

3. Prescriber Information

First name* _____ Last name* _____

Address* _____ City* _____ State* _____ ZIP* _____

Phone* _____ Ext. _____ Fax _____

Primary contact: Name* *(Clinic/facility name/office)* _____

NPI* _____ Email _____ Preferred contact: ❑ E-mail ❑ Phone ❑ Fax

Prescriber ship-to address for this product _____ City _____ State _____ ZIP _____

4. Prescription Information*

Prescription for DOPTELET® (avatrombopag) 20 mg tablets **Prescription Type** (if refills) ❑ Refills Dates _____

SELECT ONE OPTION

❑ **40 mg:** 5 Day Supply (10 Tablets) – **NDC # 71369-0020-10** – Take 2 tablets by mouth daily for 5 days beginning 10-13 days prior to scheduled procedure date

❑ **60 mg:** 5 Day Supply (15 Tablets) – **NDC # 71369-0020-15** – Take 3 tablets by mouth daily for 5 days beginning 10-13 days prior to scheduled procedure date

❑ NKDA ❑ Drug/food allergies: _____

SELECT ONE OPTION

❑ Known procedure date *(MM/DD/YYYY)* _____
Patient's 1st dosing date for DOPTELET *(MM/DD/YYYY)* _____

❑ Procedure not scheduled as of date below. SIG: Take as directed by your physician
DO NOT BEGIN DOSING UNTIL INSTRUCTED BY YOUR PHYSICIAN OR PHARMACY

Prescribers signature *(no stamps)*

SELECT ONE OPTION

X _____
❑ **Dispense as Written** Date *(MM/DD/YYYY)*

OR

X _____
❑ **Substitution Permissible** Date *(MM/DD/YYYY)*

5. *Statement of Medical Necessity*

Complete items below or provide all relevant clinical documentation to support the use of DOPTELET® (avatrombopag)

A. Are you prescribing DOPTELET per the Prescribing Information?
❑ **YES** ❑ **NO**

B. Check all that apply and attach documentation for below diagnosis:
❑ I have determined that treatment with DOPTELET is medically necessary for the above-named patient.
❑ Patient's diagnosis code (ICD 10) Chronic liver disease is _____
❑ Patient's diagnosis code (ICD 10) Thrombocytopenia is ❑ D69.59 ❑ D69.6
❑ Other _____

C. Is the patient's current baseline platelet count less than 50 x 10^9/L?
❑ **YES** ❑ **NO** *(Attach most recent lab)*

6. Prescriber Authorization

I authorize Dova Pharmaceuticals, Inc. ("Dova") as my designated agent for the purposes of conducting a benefits verification and investigation, using this form to obtain necessary information from the above-named patient's insurer and/or forwarding this prescription, by fax or other mode of delivery, to the above-named patient's pharmacy.

In addition, I certify and warrant the following: This request has been prepared exclusively by me or my office. I have obtained written authorization from the patient identified in this request to disclose the patient's personal health information (PHI), including information relating to the patient's medical condition and prescription medications and the information disclosed in this patient enrollment form, as well as the information included in this request to Dova for the purpose of application and enrollment in the DOPTELET Financial Assistance Program. I have provided the patient with the notices necessary to comply with all federal and state laws related to the privacy of health information, including but not limited to HIPAA. I will not submit an insurance claim or other claim for reimbursement to any government or private third-party payor for medication provided by Dova to the above-named patient nor will I count any no-cost medicine toward the above-named patient's true out-of-pocket costs (TrOOP). I will notify Dova immediately if I become aware that this patient's insurance or income status has changed.

I authorize Dova 1Source to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

I verify that the information I have provided is accurate and complete to the best of my knowledge.

X _____

Prescriber signature* Date* *(MM/DD/YYYY)*

For Full Prescribing Information, visit doptelet.com

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DOVA 1SOURCE™ PROGRAM AUTHORIZATION AND CONSENT FORM

Fax: 855-686-8729
E-mail: info@Dova1Source.com
Online: Dova1Source.com
Phone: 833-368-2663

Please sign and fax/e-mail the completed form or complete patient e-consent online at dova1source.com.

First name _____ Last name _____ DOB *(MM/DD/YYYY)* _____

Authorization To Use/Disclose Personal Health Information

Dova 1Source Program (the "Program") provides services which vary from patient to patient, and may include prescription management, support in securing reimbursement, referrals to patient financial support programs, drug shipment and refills outreach, compliance and persistency messaging to the patient and the patient's physician, and no-cost medication to qualified patients prescribed Dova Pharmaceuticals, Inc. ("Dova") medications (collectively, the "Program Services").

This authorization will allow the patient's healthcare provider(s) and health insurer(s) to share information with Dova Pharmaceuticals, Inc., its employees, including field representatives, agents and subcontractors (collectively, "Dova"), so that Dova can provide the patient with the Program Services for which the patient is eligible.

AUTHORIZATION: By signing this authorization, I (the patient or the patient's personal representative) authorize each of my physicians, pharmacists, and other healthcare providers (collectively, "Healthcare Providers") and each of my health insurers (collectively, "Insurers"), to use and/or disclose the protected health information described below to Dova solely for the use of delivering Program Services specific to me as requested by me or my physician. I understand that as part of delivering Program Services, Dova may verify the accuracy of the information provided by me or my physician and may request additional financial and insurance information. My health information may be disclosed orally or in writing, or through data transfer, facsimile, or e-mail as necessary to deliver Program Services, including to a pharmacy. I understand that a pharmacy may receive a fee from Dova in exchange for (1) providing me with certain materials and information and (2) using or disclosing certain health information pursuant to this Authorization. I understand that health information to be disclosed may include: (1) my name, birth date, address, or telephone number; (2) medical records and treatment information as necessary; (3) information about my health benefits or health insurance coverage; (4) and financial information about me. Dova may receive and use this information to administer the Program as well as determine my eligibility for specific Program Services, such as financial assistance.

I understand that, once my protected health information has been disclosed to Dova, federal privacy laws may no longer protect the information from further disclosure, but Dova has agreed to use and disclose my information only for the purposes of providing Program Services. I also understand that:

- I do not have to sign this authorization. My treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected. If I do not sign, however, I will not be eligible to receive Program Services.
- This authorization will remain in effect until I am no longer participating in the Program, at which time it will expire.
- I may revoke (cancel) this authorization by informing Dova 1Source in writing at P.O. Box 1057, Somerville, NJ 08876. I understand that canceling my authorization will not affect any use of my health information that occurred before my request was processed. If I cancel, I will no longer be able to receive Program Services.
- Dova's privacy practices may change over time. Significant changes will be communicated in a timely manner to all participants of the Program.
- I am entitled to a copy of this signed authorization.

X _____

Patient or Authorized representative signature | Authorized representative phone number | Date *(MM/DD/YYYY)*

Patient Consent and Program Services Opt-in

By signing below, I agree to let representatives from the Program contact me by phone, cellular, mail, or e-mail to provide more information about taking part in the Program Services. I hereby consent to receive autodialed and/or pre-recorded messages from or on behalf of Dova at the telephone number provided, including my wireless number, if applicable. I understand that consent is not a condition of purchase.

I understand and agree that Dova may change or discontinue the Program and Program Services at any time. Significant changes will be communicated, in a timely manner, to all participants of the Program.

I understand that I do not have to sign this consent, and I may cancel my participation in the Program, at any time, by contacting Dova 1Source at 1-833-DOVA-ONE (833-368-2663). I understand that if I do not sign this consent or cancel my participation in the Program, I will not be eligible to receive Program Services. I understand that not signing the consent or canceling my participation in the Program will not otherwise affect my treatment or insurance eligibility or benefits. My written permission ends 7 years from the date I signed it or when dictated by applicable state law.

I understand and agree that I will contact the Program if my financial status or insurance coverage changes.

X _____

Patient or Authorized representative signature | Authorized representative phone number | Date *(MM/DD/YYYY)*

Print Patient or Authorized representative name _____ Authorized representative relationship, if applicable _____

For Full Prescribing Information, visit doptelet.com

Dova PHARMACEUTICALS