

After reading and agreeing to the Authorization To Use/Disclose Personal Health Information below, print name and date of birth (DOB) at the top of the following page and sign the Patient Authorization for Dova 1Source Use. When required fields are completed on that page, fax the form to (855) 686-8729.

Authorization To Use/Disclose Personal Health Information

What you are agreeing to with the Patient Authorization:

Dova 1Source Program (the "Program") provides support to patients to help them understand what their coverage is for their prescribed therapy and connect them with support to facilitate access to Dova products which may include no-cost medicine provided through Dova's Patient Assistance Program (PAP). By signing this authorization, you are agreeing to share personally identifiable information (PII) which may consist of: 1) name, 2) birthday, 3) address, 4) telephone number, 5) e-mail address, 6) financial information, 7) necessary medical information and 8) information about your health benefits or health insurance coverage in order to provide the necessary support.

Who may see and use my PII:

I authorize my healthcare provider(s), pharmacies and health insurer(s) to share information with Dova Pharmaceuticals, Inc., its employees, appropriate field representatives, agents and subcontractors (collectively, "Dova"), so that Dova can provide me with necessary support to facilitate access to Dova products through the Program.

Purpose for sharing my PII:

- Working with my healthcare plan to understand coverage for Dova products
- Applying to the Dova PAP
- Determining my eligibility and enrollment into financial assistance services, including copay assistance
- Coordinating my prescription through a pharmacy and/or healthcare provider's office
- Providing treatment reminders and education

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 PII described above to Dova solely for the use of delivering the Program support described above as requested by me or my physician. I understand that as part of delivering Program support, Dova may verify the accuracy of the information provided by me or my physician and may request additional financial and insurance information. My PII may be disclosed orally or in writing, or through data transfer, facsimile, or e-mail as necessary to deliver Program support, including to a pharmacy. I understand that a pharmacy may receive remuneration, compensation, or payment 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. Dova may receive and use this information to administer the Program as well as determine my eligibility for specific Program support, such as financial assistance. I understand that once my PII 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 Support. Once I sign this Patient Authorization Form and my PII is transmitted to the Program, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect or prohibit the redisclosure of the PII disclosed to Dova by my healthcare provider or others covered by the HIPAA laws. I understand that Dova is committed to protecting my information and keeping it secure and confidential while it is being collected or used to assist me and that the use and disclosure of my information will be limited to that described above. 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, the Program will not be able to assist me.
- This authorization will expire in 5 years after the date it is signed unless a shorter period is mandated by state law or I revoke or cancel my authorization before then.
- I may revoke (cancel) this authorization by informing Dova 1Source in writing at P.O. Box 5490, Louisville, KY 40255. 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 Support and I will no longer be eligible to receive no-cost product from the Dova PAP.
- 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.

Dova Patient Assistance Program (PAP) — Eligibility Criteria

To be considered for the Dova Patient Assistance Program, the patient must:

- Meet the income criteria
- Be uninsured or rendered uninsured
- Be prescribed DOPTelet for an FDA-approved indication
- Have a valid US address (no PO Box)

Income criteria: gross household income of no more than \$75,000 for a one-person household, and \$25,000 for each additional household member.

Patients will have to reapply for the Dova Patient Assistance Program each calendar year.

Please see the next page for authorization signature field and additional details.

Please sign and return to Dova 1Source.
Fax: 855-686-8729 **Mail:** P.O. Box 5490, Louisville, KY 40255

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

1. Patient Authorization for Dova 1Source Use



Patient or authorized representative signature* _____ Date* (MM/DD/YYYY) _____
Print authorized representative: First name _____ Last name _____
Representative phone number _____ Relationship to patient _____

2. Dova Patient Assistance Program (PAP) — Enrollment (If applying for PAP, please complete sections 2a and 2b)

2a. Dova PAP Only — Patient Information

First name _____ Last name _____ DOB (MM/DD/YYYY) _____
Address _____ City _____ State _____ ZIP _____
Phone _____ E-mail _____

OK to leave a detailed message? YES NO OK to send a text message? YES NO

Total gross household income \$ _____ Number of people in household _____

Gross household income is the total income before income tax deductions from all people living in your household. Gross income refers not only to the salaries and benefits received, but also includes, but is not limited to, the receipts from any personal business, investments, dividends, and other income. Proof of gross income may be required. Acceptable forms of documentation include federal tax returns, Social Security benefit statements, one month's worth of paycheck stubs, and unemployment or disability statements.

Do you have insurance? YES NO

2b. Dova PAP Only — Support Authorization

I attest that the information in this application is true, correct, and complete. I agree to update Dova 1Source immediately should any of this information change, including if I become eligible for any benefit through a federal, state, or private program, which may reimburse for DOPTOLET. I understand that changes in my health insurance coverage may impact my eligibility for the Dova Patient Assistance Program ("the Program"). If I am approved and enrolled in the Program, I agree that I will not seek reimbursement for the no-cost medicine from anyone else, including a prescription insurance program or any other charity. I agree to inform my insurance provider if I receive no-cost medicine if required by my plan. I will not sell or give out the no-cost medicine because that is illegal. If I have Medicare Part D, I will not count any no-cost medicine toward my true out-of-pocket costs (TrOOP). I understand that Dova may request additional information or documentation from me at any time. I understand that Dova reserves the right to modify or terminate the Program at any time without notice. I understand that completing this application does not ensure that I will qualify for the Program. I understand that program assistance will terminate if Dova 1Source becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. I authorize Dova and its third-party administrator to use the information provided on this form to obtain a personal credit report about me to verify the information on this form and determine my eligibility for the Program.

I understand that I may need to provide proof of income or out-of-pocket expenses and I agree to provide necessary documentation in a timely manner.



Patient or authorized representative signature* _____ Date* (MM/DD/YYYY) _____
Print authorized representative: First name _____ Last name _____
Representative phone number _____ Relationship to patient _____

3. Patient Consent for Patient Marketing Opt-in (Optional)

By signing below, I agree to Dova contacting me by phone, cellular, mail, or e-mail to provide more information about DOPTOLET and information or resources related to approved use of DOPTOLET. 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 marketing efforts at any time. Significant changes will be communicated, in a timely manner, to all participants who have opted-in to receive information.

I understand that I do not have to sign this consent, and I may revoke this authorization, 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 revoke my authorization, I will not be eligible to receive marketing information. I understand that not signing the consent or revoking my authorization 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.



Patient or authorized representative signature* _____ Date* (MM/DD/YYYY) _____

For Full Prescribing Information, visit doptelet.com