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.
Asterisk indicates minimum information needed for pharmacy or PAP processing.

Dova 1Source Contact Information
Fax: 855-686-8729
Phone: 833-368-2663
Online: Dova1Source.com

Support needed ☐ Benefit Investigation ☐ Triage to Specialty Pharmacy ☐ Patient Assistance Program

1. Patient Information
Patient signature required on the Program Authorization and Consent Form.* ☐ Patient unavailable for signature. Please contact for consent.

First name* *(Print legibly)* _____ Middle Initial _____ Last name* _____
DOB* *(MM/DD/YYYY)* _____ Gender* ☐ M ☐ F Last 4 Digits of SSN* _____
Address* *(No PO Box allowed)* _____ Apt. Number* _____
City* _____ State* _____ ZIP* _____ E-mail _____
Phone* _____ ☐ Text OK ☐ Detailed voice message OK Alternate Phone _____ ☐ Text OK
Caregiver name _____ Phone _____ E-mail _____

2. Patient Insurance Information*
If patient has insurance include copies of the front and back of insurance card(s).

☐ Patient **has** insurance *[Include copies of the front and back of insurance card(s)]* **OR** ☐ Patient **does not** have insurance
Prescription drug insurer/pharmacy benefit manager *(PBM)* _____ Phone _____
Policy number _____ Rx BIN _____ Rx Group _____ Rx PCN _____

3. Prescriber Information

First name* _____ Last name* _____ Specialty* _____
NPI* _____ Office/Clinic/Institution Name* _____
Address* _____ City* _____ State* _____ ZIP* _____
Phone* _____ Ext. _____ Fax* _____ E-mail _____
Primary office contact: Name* _____
Phone* _____ Fax* _____ E-mail _____ Preferred contact: ☐ Phone ☐ Fax ☐ E-mail
Prescriber ship-to address for this product _____ City _____ State _____ ZIP _____

4. Prescription Information*

☐ **Chronic immune thrombocytopenia (ITP)**
DOPTELET (avatrombopag) is indicated for the treatment of thrombocytopenia in adult patients with chronic ITP who have had an insufficient response to a previous treatment.
ITP diagnosis code (ICD 10) is: _____
Prior treatment: _____

☐ **Thrombocytopenia (TCP) in adult patients with chronic liver disease (CLD)**
DOPTELET (avatrombopag) is indicated for the treatment of thrombocytopenia in adult patients with CLD who are scheduled to undergo a procedure.
CLD diagnosis code (ICD 10) is: _____
TCP diagnosis code (ICD 10) is: _____
Known procedure date *(MM/DD/YYYY)*: _____
Begin taking *(MM/DD/YYYY)*: _____

SELECT ONE OPTION
☐ **DOPTELET (avatrombopag) 20-mg tablets 10 ct – NDC # 71369-0020-10**
☐ **DOPTELET (avatrombopag) 20-mg tablets 15 ct – NDC # 71369-0020-15**
☐ **DOPTELET (avatrombopag) 20-mg tablets 30 ct – NDC # 71369-0020-30**

Directions: _____
Quantity/Day: _____ Days supply: _____
☐ NKDA ☐ Drug/food allergies: _____
Patient platelet count: _____ ☐ Refill(s) _____

X _____
Prescriber signature* *(no stamps)* Date* *(MM/DD/YYYY)*

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Preferred Specialty Pharmacy: Preferred pharmacy will be utilized when allowed by the payer.
☐ Accredo ☐ Biologics ☐ CVS Specialty ☐ Kroger Specialty
☐ On-site dispensing pharmacy. Name _____
Pharmacy contact. Name _____ Phone _____

SELECT ONE OPTION
☐ **Ship to patient's address in Section 1** upon approval and completion of Rx
☐ **Ship to prescriber's office in Section 3** upon approval and completion of Rx

5. Prescriber Authorization

By signing this I certify: A) I have determined the above therapy is medically necessary for the above named patient. B) I authorize Dova Pharmaceuticals, Inc. ("Dova") as my designated agent for the purposes of: conducting a benefits verification and investigation (BI), Prior Authorization (PA) research, appeal research, copay assistance and/or referral to foundation support, 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 appropriate designated pharmacy determined either by the patient's benefit plan or the above designated pharmacy. C) This request has been prepared exclusively by me or my office. D) I have obtained written authorization from the above named patient to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Dova, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, enrollment in the Dova Patient Assistance Program (PAP) or assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome. 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. E) I will not submit an insurance claim or other claim for reimbursement to any government or private third-party payor for no-cost 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). Additionally, I will notify Dova immediately if I become aware that this patient's insurance or income status has changed. F) 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™ PATIENT AUTHORIZATION AND CONSENT FORM

Dova 1Source Contact Information

Fax: 855-686-8729
Phone: 833-368-2663
Online: Dova1Source.com

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.

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Dova 1Source Contact Information
Fax: 855-686-8729
Phone: 833-368-2663
Online: Dova1Source.com

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

X _____

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 DOPTELET. 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.

X _____

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 DOPTELET and information or resources related to approved use of DOPTELET. 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.

X _____

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

For Full Prescribing Information, visit doptelet.com

Dova PHARMACEUTICALS a sobi company