Epizyme™

EpizymeNOW Patient & Product Support Enrollment Form

Patient & Product Support

Please check all support options for which you are applying:

- ❑ Insurance Related Support (Benefit Investigation, Prior Authorization, and/or Appeal Process)
- ❑ Patient Assistance Program (PAP)
- ❑ QuickStart
- ❑ Bridge Program

Please contact EpizymeNOW Patient & Product Support at the phone number below for information about financial support, including the commercial co-pay card program.

All support is subject to eligibility criteria and program terms and conditions.

Call us Monday-Friday (9 am to 6 pm ET) at:
1-833-4EPINOW (437-4669)

Fax the completed enrollment form to:
1-877-542-2731

Please refer to page 3 for instructions on filling out this form and enrolling your patient in EpizymeNOW, plus a brief description of each support program listed above.

1 Patient Information

Patient's Name: _____ (First) _____ (Last)

Sex: ❑ Male ❑ Female Date of Birth: ____/____/____ (Month / Day / Year)

Patient Address: _____

City: _____ State: _____ ZIP: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Preferred Method of Contact: ❑ Home Phone ❑ Cell Phone ❑ Email

Best Time to Contact: ❑ AM (8 am to 10 am ET) ❑ DAY (10 am to 5 pm ET) ❑ PM (after 5 pm ET)

Additional Contact: _____ (First) _____ (Last) _____ (Phone #)

Relationship: _____

2 Healthcare Professional/Facility Information

Prescriber's Name: _____ (First) _____ (Last)

Prescriber's Title: _____

NPI #: _____ DEA #: _____

Tax ID #: _____ PTAN #: _____

Facility Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Office Contact's Name: _____

Office Contact's Title: _____

Office Contact's Phone #: _____ Fax #: _____

Office Contact's Email: _____

3 Insurance Information

❑ Uninsured ❑ Medicaid ❑ Medicare ❑ Other: _____ ❑ Government Programs (please specify): _____

Primary Medical Insurance Payer: _____

Phone #: _____

Subscriber ID #: _____ Group #: _____

Subscriber Name: _____

Secondary Medical Insurance Payer: _____

Phone #: _____

Subscriber ID # : _____ Group #: _____

Subscriber Name: _____

Tertiary Medical Insurance Payer: _____

Phone #: _____

Subscriber ID #: _____ Group #: _____

Subscriber Name: _____

Pharmacy Benefit Manager (PBM): _____

PBM Name: _____

Phone #: _____

Insurance ID #: _____ Group #: _____

BIN: _____ PCN: _____

You may provide a copy of both sides of the patient's insurance card to help improve accuracy and reduce the frequency of follow-up calls.

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4 Preferred Specialty Pharmacy (Select one): ❑ Onco360 ❑ Approved On-Site Self-Dispensing Pharmacy

TAZVERIK™ (tazemetostat) has a limited distribution network, which currently consists of Onco360. TAZVERIK will be delivered to the patient's home unless "Approved On-Site Self-Dispensing Pharmacy" is selected in this section.

5 TAZVERIK™ (tazemetostat) Prescription

Patient's Name: _____

Date: ____/____/____ (Month / Day / Year) Rx for Quantity: _____

Refills: _____ Start Date: ____/____/____ (Month / Day / Year)

Direction for Use: Take _____ 200 mg tablet(s) orally twice daily

(total _____ mg per dose)

Additional Directions: _____

Prescriber's Name: _____

Prescriber's Signature: _____ Date: ____/____/____ (Month / Day / Year)

Be sure to attach a separate prescription if this section does not comply with your state's prescription law.

6 Clinical Information

Patient's Diagnosis:

ICD-10 Code: _____ Diagnosis Date: ____/____/____ (Month / Day / Year)

Most Recent Therapies for this Diagnosis:

_____

_____

_____

Prior Therapies for this Diagnosis:

_____

_____

_____

ICD-10 code is a required field. Providing additional information in this section may help reduce the frequency of follow-up calls.

7 Patient Authorization

I hereby authorize my healthcare professionals, my health insurance company, and my pharmacy to disclose my protected health information ("PHI") including, but not limited to, my name, address, telephone number, medical records, health insurance coverage, and financial information to Epizyme and its representatives/agents ("Epizyme") so that Epizyme may use my information: (a) to contact me, or the person legally authorized to sign on my behalf, by phone or mail, regarding this application, my participation in the Program, and my use or potential use of TAZVERIK, including through messages left for me that disclose that I take or may take TAZVERIK, (b) to contact my insurance company on my behalf to verify my coverage for TAZVERIK, (c) to determine my eligibility for enrollment into EpizymeNOW Patient & Product Support (the "Program"); (d) to enroll me into the Program, if I am eligible, and provide applicable support through the Program, including information on third-party sources that may be able to assist me; (e) to coordinate my Epizyme treatment with my healthcare professionals and specialty pharmacy, and send me educational materials or other information that may be of interest to me related to my Epizyme treatment; and (f) to conduct other activities as appropriate to administer the Program. I understand and authorize that the information provided by me, my healthcare professional, pharmacy or insurance company may be used for marketing purposes about Epizyme, its products, or its patient support programs. I understand that my healthcare and/or pharmacy provider(s), and/or my insurance company, may receive remuneration in exchange for the provision of my PHI for use in marketing and for other authorized purposes. Once my health information has been disclosed to Epizyme, I understand that federal privacy laws may no longer protect the information. However, I understand that Epizyme, and other companies authorized to receive my health information pursuant to this Authorization agree to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that this authorization does not affect treatment from my healthcare professional or coverage for TAZVERIK through my insurance. I understand this authorization is voluntary. However, if I refuse to sign, or cancel my authorization, Epizyme may not be able to determine my eligibility for the Program and I may not be eligible to participate in the Program. I may cancel this authorization at any time by contacting Epizyme at 1-833-4EPINOW (437-4669). If I do not cancel the authorization, it will remain valid for 3 years (or at such lesser time as state law may require). I understand I am entitled to receive a copy of this authorization.

Patient's Signature: _____ Date: ____/____/____ (Month / Day / Year)

Legal Representative Signature (if applicable): _____ Date: ____/____/____ (Month / Day / Year)

8 Patient Assistance Program (PAP) Enrollment (if applicable)

I certify that the information provided on this form is complete and accurate, to the best of my knowledge, and I will promptly call Epizyme at 1-833-4EPINOW (437-4669) with any updates, including any changes to my insurance. I understand that all support provided through EpizymeNOW Patient & Product Support (the "Program") is complimentary, and there is no purchase requirement associated with the Program. To determine my eligibility to enroll into the Patient Assistance Program, Epizyme and its representatives/agents ("Epizyme") will assess my income with the appropriate level of evidence set forth by verification of financial information (including W-2 and tax return documentation). I will not seek (or allow others to seek on my behalf) payment or reimbursement for any free drug or other support provided to me through the Program. I will comply with all Program terms and conditions and with any requirements from my insurance provider.

Patient's Signature: _____ Date: ____/____/____
Month Day Year

Legal Representative Signature (if applicable): _____ Date: ____/____/____
Month Day Year

9 Healthcare Professional Certification

By signing below, I hereby represent, covenant, and certify as follows: (1) The above therapy (or medicine) is medically necessary; (2) I have obtained from my patient his or her consent and any required written authorization as required by HIPAA and other federal or state laws to release to Epizyme, Inc.™ and its representatives/agents ("Epizyme") all patient information needed for processing this application, including, without limitation, my patient's financial and medical information; (3) I understand and my patient has authorized that this information may be used by Epizyme to assess the patient's eligibility for participation in EpizymeNOW Patient & Product Support (the "Program") and for other purposes as outlined in the Patient Authorization below; (4) Epizyme is authorized to contact me about the information provided on this form and as needed to facilitate my patient's enrollment and participation in the Program; (5) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient through the Program's free-drug support ("Epizyme Product Support"); (6) If the above-named patient is enrolled in Epizyme Product Support, free TAZVERIK™ (tazemetostat) will be provided to this eligible and enrolled patient at no charge of any kind; free TAZVERIK that is supplied as a result of this enrollment form is for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. I understand that Epizyme may, if authorized by the patient, contact the patient directly to verify Program eligibility and updates to insurance coverage as well as to confirm the receipt of free TAZVERIK through the Program; (7) I have not received, nor will I seek or accept payment from my patient or any other payer for any co-insurance or other cost-sharing amount paid for by the Program; (8) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this Program. I will promptly notify Epizyme by calling 1-833-4EPINOW (437-4669) if I become aware of any such changes; (9) I understand that any Epizyme products and other support provided by the Program are complimentary and for the benefit of the patient, that I am under no obligation to prescribe any Epizyme drugs, including because of my patient's participation in the Program, and I have not received and will not receive any benefit from Epizyme for prescribing an Epizyme drug; (10) I understand that if I receive free Epizyme product, I will only administer it to the patient for whom it was prescribed or return the product to Epizyme; (11) the information contained in this form is complete and accurate to the best of my knowledge; and (12) I will promptly notify Epizyme of any errors by calling 1-833-4EPINOW (437-4669), and will make every effort to correct those errors.

Healthcare Professional's Name: _____
First Last

Healthcare Professional's Signature (no stamps please): _____ Date: ____/____/____
Month Day Year

How to enroll in EpizymeNOW Patient & Product Support:*

1. **Complete all pages** of this form.
2. **Patient to sign and date** the Patient Authorization and PAP Enrollment Authorization (if applicable) Sections 7 and 8 on pages 2-3.
3. **Healthcare Professional to sign and date** Section 9 on page 3.
4. **Fax** completed enrollment form to: **1-877-542-2731**.

Please complete form in its entirety to help prevent processing delay(s).

*Enrollment and participation is subject to eligibility criteria and program terms and conditions.

Description of EpizymeNOW Patient & Product Support

- **Insurance Related Support** (Benefit Investigation, Prior Authorization, and/or Appeal Process)
- **Patient Assistance Program** (PAP) Provides a supply of free product for the remainder of the current calendar year, in accordance with the treating physician's on-label prescribing decision, for eligible patients who have financial need and are uninsured, rendered uninsured, or underinsured as determined by the program.
- **QuickStart** - Allows clinicians to initiate TAZVERIK treatment in accordance with on-label prescription for eligible patients whose prior authorization decision takes longer than 5 business days.
- **Bridge** - Provides an emergency supply of free product to eligible patients currently on therapy, in accordance with on-label prescription, who experience an unexpected disruption in product coverage or supply exceeding 5 calendar days (e.g. the patient's insurance provider unexpectedly requires an updated prior authorization, or in the case of a change or loss of insurance).