Enrollment Form Instructions

Fax the completed enrollment form to:
- **1-844-ONCOPEP (1-844-662-6737)**

Call us Monday-Friday (9am to 5pm ET) at:
- **1-844-300-ONCO (1-844-300-6626)**

How to enroll in ON COURSE:

FÈ Ú|^æ•^ Á**complete form in its entirety**Á[Á@|] Á¦^ç^}oÁ¦[&^••ã*Áå^|æêÇ•D

GÈ Complete both pages of this enrollment form.

HÈ Patient to sign and date the Patient Consent Section 6.

I È Healthcare Professional to sign and date Section 5.

Í È Fax completed enrollment form to ON COURSE at 1-844-662-6737

Instructions Guide

Sections 1 and 2:

Healthcare] rofessional and] atient contact information is required in this section. Be sure to include NPI and DEA numbers.

Section 3:

Select preferred shipping location for dispense.

Section 4:

This section can serve as the prescription for PEPAXTO (melphalan flufenamide) for the Patient Assistance Program (PAP) patients. **Be sure to attach a separate prescription if this section does not comply with your state's prescription law.** PEPAXTO (melphalan flufenamide) will be delivered to the preferred shipping location provided in section 3.

Section 5 and 6:

Requires a patient (or a legal representative) and a healthcare professional's signature. A healthcare professional's signature is required to attest to the review of the certification and consent.

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ON COURSE™ with oncopeptides

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Please see the instructions guide for quick reference on how to fill out this form for PEPAXTO (melphalan flufenamide)

All services and programs are subject to eligibility requirements.

1. Healthcare Professional /Facility Information

Prescriber's Name:________________________________
First Name Last Name

Prescriber's Title: ________________________________

NPI #: ________________ DEA #: ________________

Tax ID #: ________________ PTAN #: ________________

Facility Name: ________________________________

Mailing Address: ________________________________

City: ________________ State: ______ Zip: __________

____

Office Contact's Title: ________________________________

Office Contact's Phone #: ______________ Fax #: __________

Office Contact's Email: ________________________________

Preferred Method of Contact: Phone ❑ Fax ❑ Email ❑

2. Patient Information

Patient's Name: ________________________________
First Name Last Name

Sex: ❑ Male ❑ Female Date of Birth: ______ / ______ / ______

Patient Address: ________________________________

City: ________________ State: ______Zip: __________

Home Phone #: ____________Cell Phone #: ______________

Email: ________________________________

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

Ok to text: ❑ **Yes** ❑ No (Rates may apply)

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

Caregiver Name:________________________________
First Name Last Name

Caregiver Phone:________________________________

3. Preferred Shipping Location

Facility Name: ________________________________ Office Contact's Name: ________________________________

Mailing Address: ________________________________ City: ________________________________

State: __________ Zip: ________________ Phone #: ________________________________

4. Prescription Information

Patient's Name: ________________________________ DOB: ______ / ______ / ______

PLEASE NOTE: Due to the product's withdrawal from the market, this may be the final Rx fill provided via the Oncopeptides Patient Assistance Program.

Rx for PEPAXTO (melphalan flufenamide) 20mg/50ml Quantity: 90 Day Supply: ❑ Other: ______________ **Start Date:** _____ /______/_______

Directions for Use: Administer _________ mg via IV every 28 days Current Medications :________________________________

Known Drug Allergies:________________________Additional Directions:________________________________

Prescriber's Name:________________________________

Patient's Diagnosis: ________________________ ICD-10 Code ____________ Diagnosis Date: __________ Prescriber's

Signature ________________________________ Date: _________ / _________ / __________

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5. 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 hereby attest that my patient is an existing PEPAXTO patient; defined as a patient who has received at a PEPAXTO prescription on or prior to October 22, 2021, and is receiving benefit from the product.(3) 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 ON COURSE (Oncopeptides Inc. Patient Access and Support Services) and its representatives/agents all patient information needed for this application, including, without limitation, my patient's financial and medical information; (4) I understand that this information is for the sole use of ON COURSE and its representatives/agents to assess the patient's eligibility for participation in ON COURSE including ON COURSE Support 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 by Pepaxto (melphalan flufenamide) Patient Assistant Program (PAP); (6) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program. I will notify ON COURSE if I become aware of any such changes; (7) I understand that PAP product received for this patient is meant solely for this patient, and will otherwise be returned or properly destroyed / discarded; (8) I understand that I am under no obligation to prescribe any Oncopeptides, Inc. drug and I have not received and will not receive any benefit from Oncopeptides, Inc. for prescribing a Oncopeptides, Inc. drug; (9) the information contained in this form is complete and accurate to the best of my knowledge; and (10) I will notify ON COURSE of any errors regarding the foregoing, and will make every effort to correct those errors.

Healthcare Professional's Name______________________________

Healthcare Professional's Signature (no stamps please)______________________________

Date: _______ / _______ / _______

6. Patient Authorization for Disclosure of Medical Information

I hereby authorize my healthcare professionals, my health insurance company, and my pharmacy to (1) 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 ON COURSE and its agents; (a) To contact me, or the person legally authorized to sign on my behalf, by phone or mail, (b) to contact my insurance company on my behalf to verify my coverage for PEPAXTO (melphalan flufenamide), (c) To determine my eligibility for enrollment in the (melphalan flufenamide) Patient Assistant Program (PAP), including verification of my financial information; (2) Provide information regarding independent third-party foundations for assistance or alternate sources of funding or coverage that may be available to provide assistance with out- of-pocket expenses; (3) Coordinate my treatment with my healthcare professionals and specialty pharmacy, and send me educational materials or other program information that may be of interest to me. (4) I understand the information provided by me, my healthcare professional, or insurance company may be used for marketing purposes. (5) Once my health information has been disclosed to ON COURSE, I understand that federal privacy laws may no longer protect the information. (6) However, I understand that Oncopeptides, Inc. 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. (7) I understand that this authorization does not affect treatment from my healthcare professional or coverage for PEPAXTO (melphalan flufenamide) through my insurance. (8) I understand this authorization is voluntary. (9) However, if I refuse to sign, or cancel my authorization, ON COURSE may not be able to determine my eligibility for the PEPAXTO Copay Card Program and PEPAXTO (melphalan flufenamide) Patient Assistant Program (PAP). (10) If I do not withdraw 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. (11) I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address of my healthcare professional. My revocation will be effective upon receipt, but will not be effective to the extent that the recipient or other have acted in reliance upon this authorization.

Patient's Signature ______________________________ Date: _______ / _______ / ______

Legal Representative Signature ______________________________ Date**:** _______ / _______ / ______

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