Commercial Enrollment Form

1 PATIENT INFORMATION

Please provide the following information about your patient. All fields are required unless otherwise noted.

Patient first name _____ Patient middle initial _____ Patient last name _____

Date of birth (MM/DD/YYYY) _____ Age _____ ◯ Male ◯ Female ◯ Nonbinary Last four digits of social security number _____

Mailing address (for medication delivery)

Street address _____ City _____ State _____ ZIP _____

Mobile phone number (preferred) _____ Home phone number (optional) _____

Email address _____

Name of caregiver (optional) _____ Relation of caregiver _____

Primary mobile phone number of caregiver _____ Email address of caregiver _____

2 PATIENT DIAGNOSIS

Please select the diagnosis code you have given your patient with PK deficiency.

◯ D55.21: Anemia due to pyruvate kinase deficiency
◯ D55.8: Other anemias due to enzyme deficiency/disorders
◯ D58.9: Hereditary hemolytic anemia, unspecified
◯ D55.29: Anemia due to other disorders of glycolytic enzymes
◯ D55.9: Anemia due to enzyme disorder, unspecified

If your patient does not have a diagnosis code, please contact your Patient Support Manager (PSM). Your PSM will contact you to convey additional information.

3 INSURANCE INFORMATION

Please check and provide information about your patient's insurance(s).
All fields are required unless otherwise noted.
Be sure to include a copy of both sides of your patient's insurance card(s).

Patient insurance (check all that apply): ◯ No insurance ◯ Medicare ◯ Medicaid ◯ Commercial/private ◯ Other

Primary health insurance

Plan name _____
Phone # _____
Policy ID # _____
Group # _____

Policy holder (if other than patient)

Name _____
Date of birth (MM/DD/YYYY) _____

Prescription drug insurance

Plan name _____
Phone # _____
Policy ID # _____
Group # _____
RX BIN # _____
PCN # _____

Secondary insurance

Plan name _____
Phone # _____
Policy ID # _____
Group # _____

Policy holder (if other than patient)

Name _____
Date of birth (MM/DD/YYYY) _____

4 CHECK BELOW FOR PYRUKYND® (MITAPIVAT) TABLETS PRESCRIPTION

Please be sure to fill in all the information below, including the number of refills.
All fields are required unless otherwise noted.

Patient name _____ Date of birth (MM/DD/YYYY) _____

Rx start date (MM/DD/YYYY) _____

PYRUKYND Dosage Instructions:
SIG: _____

Quantity: _____ Refills: _____

How Supplied:

- 5 mg BID Treatment Pack (28-Day)
- 20 mg BID Treatment Pack (28-Day)
- 50 mg BID Treatment Pack (28-Day)

Please list any specific instructions you would like to provide to your patient:

_____

◯ Dispense as written (DAW)

Physician Signature _____ Date _____
(Dispense as written).

No stamps. NY providers must submit a valid NY prescription or eScribe to dispensing pharmacy.

5 PRESCRIBER & PRACTICE CONTACT INFORMATION AND DECLARATION

Please provide the following information about you and your practice.
All fields are required unless otherwise noted.

Prescriber name _____

Prescriber specialty
◯ Hematologist/Oncologist
◯ Hematologist ◯ Other

Practice name _____ Practice staff contact name _____

Street address _____ City _____ State _____ ZIP _____

Practice staff contact phone number _____ Fax number _____ Practice staff contact email address _____

NPI number _____ Medicare/Medicaid provider number _____ Provider Transaction Access Number (PTAN) _____

Tax ID _____ State license number _____

Your patient has previously taken this medication (eg, in the clinical trials ACTIVATE or ACTIVATE-T) ◯

Trial ID _____

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed PYRUKYND based on my judgment of medical necessity, and in accordance with its labeled indication I will be supervising my patient's treatment. I authorize, if appropriate, the forwarding of this prescription to an authorized specialty pharmacy on behalf of myself and my patient. I understand that neither I nor my patient may seek reimbursement from any government program or third-party insurer for any free product received under the program. I certify that I have obtained my patient's authorization to release the above information and such other information as may be required by Agios or its agents to assist my patient in obtaining coverage for PYRUKYND, to assist my patient in initiating or continuing PYRUKYND therapy, and to provide financial assistance to my patient.

Physician Signature _____ Date _____

To complete the enrollment process, please be sure to complete all pages 1-4,
and then fax it to myAgios Patient Support Services at 1-800-951-7814

6 PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION (REQUIRED)

Please have your patient agree to the terms below. All fields are required unless otherwise noted.

I understand that myAgios Patient Support Services is a service offered by Agios Pharmaceuticals, Inc. to help eligible patients who have been prescribed PYRUKYND® (mitapivat) tablets obtain insurance coverage and financial assistance for PYRUKYND, including through its Coverage Interruption and Patient Assistance Programs (the "Programs"). I give permission for my physician and their staff to disclose my health and other personal information, including, but not limited to the information on this form, to Agios Pharmaceuticals, Inc. and its agents and representatives (collectively "Agios") so that Agios may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans, and other third-party payers and patient assistance groups (collectively, "Third Parties") in order to: (1) enroll me in the Programs; (2) facilitate the filling of my prescription for and the delivery and administration of PYRUKYND; (3) assist me in obtaining insurance coverage for PYRUKYND; (4) contact me about PYRUKYND and the Programs (this may include supplemental educational materials, information, offers, and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys, or interviews); and (5) manage the Programs. I further authorize the Third Parties to disclose health and other personal information about me in their possession to Agios in order to assist Agios in accomplishing the purposes described above. I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act) or state privacy laws and may be further disclosed to others. However, I understand that Agios will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent. I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive PYRUKYND that is paid for by my insurer, my treatment, payment for treatment, eligibility for or enrollment in health benefits, but it will limit my ability to receive support services for PYRUKYND, including participation in free medication programs. I understand that this authorization will remain in effect for 3 years, or a shorter period as may be required by state law, from the date of my signature, unless I revoke it earlier by contacting Agios in writing at AllCare c/o Agios Patient Support Services, 50 Bearfoot Rd, Northborough, MA, 01532. If I revoke this authorization, Agios and any Third Parties who are notified of my revocation will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization. I understand that the services described in this authorization may be reduced at any time, without prior notification. However, if any services are added, Agios will obtain my authorization to receive any such additional services. I understand that certain Third Parties may receive compensation in exchange for their disclosure of my information to Agios. I also understand that I have the right to receive a copy of this authorization. I verify the information provided is true and correct. If I am the caregiver/representative for the patient, I confirm I am authorized to sign on behalf of the patient.

Patient name _____ Caregiver/Guardian name _____

Patient Signature _____ Date _____

Caregiver/Guardian Signature _____ Date _____

7 CONSENT TO RECEIVE MATERIAL FROM AGIOS (OPTIONAL)*

By enrolling in myAgios Patient Support Services, you may receive support and educational materials on pyruvate kinase deficiency and PYRUKYND® (mitapivat) tablets.

By clicking "I Agree," I consent that the information I am providing may be used by Agios and its agents to keep me informed about products, patient support services, or other opportunities that may be of interest to me via mail or email. Agios may also combine the information I provide with information about me from third parties to better match information with my interests. You may receive mail or emails that contain information to support and educate on pyruvate kinase deficiency as well as those that market or advertise Agios products or services. I understand from time to time, Agios' Online Privacy Policy may change and for the most recent version of the Online Privacy Policy, I should visit myAgios.com/privacypolicy.

Agios understands protecting your personally identifiable information is very important. We do not share any personally identifiable information you give us with third parties for their own marketing use.

Please see **Important Safety Information** below and accompanying **Full Prescribing Information**.

☐ I agree

Please have your patient agree to each of the following statements:

☐ I understand that I will receive educational information and updates about PK deficiency, research opportunities, and other information that may be of interest to me from Agios.

☐ I consent to receive phone calls and text messages from and on behalf of Agios [and its affiliates] that contain information to support and educate on pyruvate kinase deficiency as well as those that market or advertise Agios products or services at the phone number(s) I provide. I understand that my consent is not required or a condition of purchasing goods or services from Agios.

*Patient is under no obligation to complete Section 7 to receive their prescription or to enroll in the Patient Support Program.

8 SUBMIT FORM

Just one more step to go. To complete the enrollment process, please be sure to download your completed form, print it, and then fax it to myAgios Patient Support Services at 1-800-951-7814.

INDICATION

PYRUKYND is a pyruvate kinase activator indicated for the treatment of hemolytic anemia in adults with pyruvate kinase (PK) deficiency.

IMPORTANT SAFETY INFORMATION

Acute Hemolysis: Acute hemolysis with subsequent anemia has been observed following abrupt interruption or discontinuation of PYRUKYND in a dose-ranging study. Avoid abruptly discontinuing PYRUKYND. Gradually taper the dose of PYRUKYND to discontinue treatment if possible. When discontinuing treatment, monitor patients for signs of acute hemolysis and anemia including jaundice, scleral icterus, dark urine, dizziness, confusion, fatigue, or shortness of breath.

Adverse Reactions: Serious adverse reactions occurred in 10% of patients receiving PYRUKYND in the ACTIVATE trial, including atrial fibrillation, gastroenteritis, rib fracture, and musculoskeletal pain, each of which occurred in 1 patient. In the ACTIVATE trial, the most common adverse reactions including laboratory abnormalities (≥10%) in patients with PK deficiency were estrone decreased (males), increased urate, back pain, estradiol decreased (males), and arthralgia.

Drug Interactions:

- Strong CYP3A Inhibitors and Inducers: Avoid concomitant use
- Moderate CYP3A Inhibitors: Do not titrate PYRUKYND beyond 20 mg twice daily
- Moderate CYP3A Inducers: Consider alternatives that are not moderate inducers. If there are no alternatives, adjust PYRUKYND dosage
- Sensitive CYP3A, CYP2B6, CYP2C Substrates Including Hormonal Contraceptives: Avoid concomitant use with substrates that have narrow therapeutic index
- UGT1A1 Substrates: Avoid concomitant use with substrates that have narrow therapeutic index
- P-gp Substrates: Avoid concomitant use with substrates that have narrow therapeutic index

Hepatic Impairment: Avoid use of PYRUKYND in patients with moderate and severe hepatic impairment.

Please see full Prescribing Information for PYRUKYND.