How to complete the PYRUKYND® Start Form*

The PYRUKYND Start Form serves as the prescription for PYRUKYND® (mitapivat). Complete it to connect the patient to myAgios® Patient Support Services, which includes access, financial support eligibility, and prescription triage. Please complete required fields depending on the services needed and fax a printed version to myAgios at 1-800-951-7814. **Incomplete information may result in delays in getting patients started on therapy**. Use this guide to ensure the form has been completed correctly and for direction on where to send the form.

*Please use a computer to edit the Start Form PDF. If you need to use a mobile device, save/download the PDF to your mobile device and open it in a PDF editor or native phone application, outside of the mobile device default browser.

PYRUKYND® Start Form

A

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 Last four digits of Social Security number _____

Patient preferred language:

◯ English ◯ Spanish ◯ Other language: _____

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 _____

B

2 PATIENT DIAGNOSIS AND PYRUKYND® (MITAPIVAT) TABLETS PRESCRIPTION

PK deficiency:

◯ D55.21: Anemia due to pyruvate kinase deficiency

◯ Other: _____

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.

C

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) _____

Select strength/quantity for PK deficiency:

◯ 5 mg tablets x 28-day supply (56 tablets)

◯ 20 mg tablets x 28-day supply (56 tablets)

◯ 50 mg tablets x 28-day supply (56 tablets)

SIG: ◯ Take 1 tablet by mouth twice daily

◯ Other (please specify): _____

Refills: ◯ 11 ◯ Other (please specify): _____

Prescriber Signature _____ Date _____

Name of supervising physician _____
(If required).

D

No stamps. NY providers must submit a valid NY prescription or eScribe to the exclusive Specialty Pharmacy for PYRUKYND, Biologics.

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
For questions, call **1-877-77-AGIOS (1-877-772-4467)**, [Mon-Fri, 8 AM to 8 PM ET]

1

A **Please note that the PYRUKYND Start Form must be completed to enroll your eligible patients to receive benefits investigation and financial support services, if eligible for myAgios.**

If you have questions about where to send this form, please call myAgios at 1-877-77-AGIOS (1-877-772-4467).

B **Each patient's ICD-10 diagnosis code is required for prescription fulfillment through myAgios or through our exclusive specialty pharmacy.**

If your patient does not yet have a diagnosis code, please contact your Patient Support Manager.

C **Section 2 must be completed in its entirety for a PYRUKYND prescription to be fulfilled through the exclusive specialty pharmacy using the patient's insurance.**

A prescriber **must** provide their signature and the date in section 2, as this acts as the PYRUKYND prescription.

Please complete the dosage instructions appropriately and legibly, as missing or unclear information may cause delays.

Prescriber signature and date is required.

D **NY providers must submit a valid NY prescription or eScribe to dispensing pharmacy.**

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E

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 # _____

F

4 PRESCRIBER & PRACTICE CONTACT INFORMATION AND DECLARATION

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

Practice staff contact name _____

Practice staff contact email address _____

Practice staff contact phone number _____

Prescriber name _____

Prescriber specialty
◯ Hematologist/Oncologist ◯ Hematologist
◯ Primary care provider

Practice name _____

Street address _____ City _____ State _____ ZIP _____

NPI number _____ Fax number _____

If your patient has participated in a clinical trial, please include the trial identification code:

G

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.

Prescriber Signature _____ Date _____

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For questions, call **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM ET

2

E **Patient insurance information is required to determine the patient's coverage for PYRUKYND and the level of support needed. Submitting the form with this section blank or partially completed may cause delays.**

Please include a copy of both sides of the patient's insurance card(s).

F **Section 4 must be completed in its entirety. Incomplete information may cause delays with benefits investigation toward product fulfillment.**

Prescriber signature and date are required.

G If the patient has previously or is currently enrolled in a clinical trial with mitapivat, this information will help to identify additional communications necessary to the Agios clinical development team.

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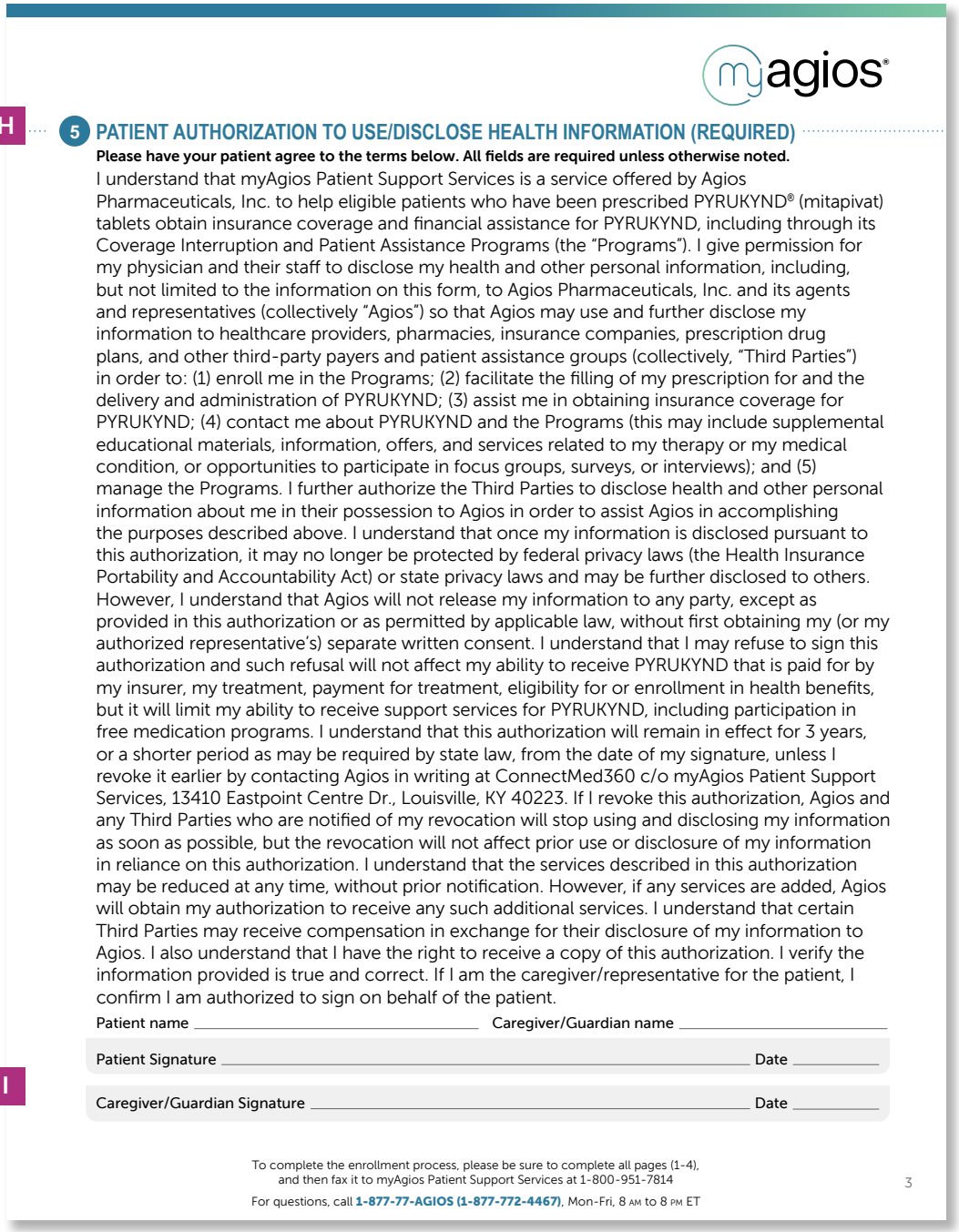

H

5 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 ConnectMed360 c/o myAgios Patient Support Services, 13410 Eastpoint Centre Dr., Louisville, KY 40223. 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 _____

I

Caregiver/Guardian 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

For questions, call **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM ET

3

H **Please review this patient authorization to use/disclose health information statement with the patient or caregiver.**

This section must be completed in its entirety. Incomplete patient/caregiver signature and date may cause delays with benefits investigation toward product fulfillment.

I **Patient signature and date are always required. If patient signature and date are not obtained, myAgios cannot initiate the benefits investigation with the patient's insurance plan.**

The caregiver/guardian signature and date are required for an adult patient (18+) who grants permission to their caregiver/guardian to speak to myAgios on their behalf.

You may also have the patient talk with a myAgios Patient Support Manager to provide verbal consent (valid for 30 days) or e-consent (valid for 3 years) **Please call 1-877-77-AGIOS (1-877-772-4467) with any questions.**

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J

6 CONSENT TO RECEIVE SMS TEXT FROM AGIOS (OPTIONAL)*

By enrolling in myAgios Patient Support Services, you may receive SMS text messages with appointment reminders and other healthcare-related communications.

◯ By checking this box, I consent to receive text messages from Agios Pharmaceuticals. Reply STOP to opt out. Reply HELP for assistance. Message and data rates may apply. Message frequency may vary. I understand that this consent is not required or a condition of purchasing or obtaining goods or services from Agios. Review Privacy Policy for additional information: https://www.agios.com/privacy-notice/.

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

*Patient's consent to Section 6 is not required or a condition of purchasing or obtaining products or services from Agios.

K

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 and service providers to keep me informed about Agios products, patient support services, or other opportunities that may be of interest to me via mail and/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. Agios understands protecting your personally identifiable information is very important. 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/privacy policy.

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

◯ I agree.

Please present the following checkbox and statement to your patients as an option for patients to agree to when signing the Patient Authorization form:

◯ 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 mail or email from or on behalf of Agios [and its affiliates] that contain information on research opportunities, as well as those that market or advertise Agios products or services at the mailing address or email I provide on this form. I understand that this consent is not required or a condition of purchasing or obtaining 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.

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

For questions, call **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM ET

J **The patient or caregiver must provide consent to receive SMS text messages from Agios. This is optional for the patient or caregiver.**

K **The patient or caregiver must provide consent if they want to receive materials through Agios. This is optional for the patient or caregiver.**

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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.

M

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.

Hepatocellular Injury in Another Condition: In patients with another condition treated with mitapivat at a higher dose than that recommended for patients with PK deficiency, liver injury has been observed. These events were characterized by a time to onset within the first 6 months of treatment with peak elevations of alanine aminotransferase of >5× upper limit of normal (ULN) with or without jaundice. All patients discontinued treatment with mitapivat, and these events improved upon treatment discontinuation.
Obtain liver tests prior to the initiation of PYRUKYND and monthly thereafter for the first 6 months and as clinically indicated. Interrupt PYRUKYND if clinically significant increases in liver tests are observed or alanine aminotransferase is >5× ULN. Discontinue PYRUKYND if hepatic injury due to PYRUKYND is suspected.

Adverse Reactions: 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.

N

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

Please see full Prescribing Information for PYRUKYND.

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

For questions, call **1-877-77-AGIOS (1-877-772-4467)**, Mon-Fri, 8 AM to 8 PM ET

L Download the form, complete the required fields, sign and date the prescription and prescriber declaration, and review consent with patient if possible, then fax a printed version to myAgios Patient Support Services at 1-800-951-7814.

M Please review the Indication and Important Safety Information with the patient or caregiver.

N A dedicated Agios Clinical Educator and Patient Support Manager will reach out to office staff and patients directly to provide support throughout the treatment process.

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