IPSEN CARES® MEDICATION SUPPORT NURSE PROGRAM ENROLLMENT FORM

Questions? Call IPSEN CARES at 1-866-435-5677

TAZVERIK® (tazemetostat) tablets 200 mg

Please fill out this form completely and then fax to 1-888-525-2416

By completing this enrollment form, you may be eligible to receive individualized support provided by an IPSEN CARES nurse, including:

- Education about your condition and treatment with TAZVERIK
- Help identifying potential gaps in care throughout your treatment journey
- Support to help you receive your medication in a timely manner

An IPSEN CARES Medication Support Nurse will reach out after enrollment.
Please save this phone number in your contacts – 1-866-435-5677

Medication Support Nurses are provided by Ipsen and do not work under the direction of the patient's healthcare provider or give medical advice. Remember to talk to your doctor about treatment-related questions.

You will receive a call from 1-866-435-5677

STEP 1

PATIENT INFORMATION

Patient Name (First & Last) _____

Patient Address _____

City _____

State _____ Zip _____

Date of Birth (MM/DD/YY) ____ / ____ / ____

Email _____

Prescribing Doctor Name _____

Home Phone # _____

Mobile Phone # _____

Caregiver/Legal Guardian Name (First & Last)

_____

Caregiver/Legal Guardian Phone # _____

Relationship to Patient _____

Prescribing Doctor Phone # _____

Diagnosis:

○ Epithelioid Sarcoma (ES) ○ Follicular Lymphoma (FL) ○ Other _____

TAZVERIK is a prescription medicine used to treat:

- Adults and children aged 16 years and older with epithelioid sarcoma that has spread or grown and cannot be removed by surgery.
- Adults with follicular lymphoma when the disease has come back or did not respond to treatment, whose tumors have an abnormal EZH2 gene, **and** who have been treated with at least two prior medicines. Your healthcare provider will perform a test to make sure TAZVERIK is right for you.
- Adults with follicular lymphoma when the disease has come back or did not respond to treatment, who have no other satisfactory treatment options.

The approval of TAZVERIK in these patients is based on studies that measured the percentage of patients whose tumor shrank or disappeared after treatment and how long that response lasted. TAZVERIK is still being studied to confirm these benefits.

It is not known if TAZVERIK is safe and effective in children less than 16 years of age.

I give permission to Ipsen to contact me by text message for the purposes described in Step 2 on Page 3. ○ Yes ○ No

If Yes, please initial here: _____

TAZVERIK® (tazemetostat) tablets 200 mg

Please fill out this form completely and then fax to 1-888-525-2416

STEP 2

PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION: IPSEN CARES® PROGRAM

I authorize my doctor(s) and their staff (including those pharmacies that may receive my prescription for Tazverik®) to disclose my protected health information ("PHI"), including health information about insurance, prescription, care management, and medical condition to Ipsen Biopharmaceuticals, Inc., and/or its affiliates, and/or its agents or third-party vendors that have been hired to administer the Ipsen Coverage, Access, Reimbursement & Education Support (IPSEN CARES) program (collectively, "Ipsen") in order for Ipsen to (1) enroll me in the IPSEN CARES Medication Support Nurse Program; (2) communicate with my doctors and health plans about my treatment plan; (3) provide support services, including patient education for Tazverik; (4) help get Tazverik shipped to me or my healthcare provider; and (5) facilitate my participation in Tazverik patient programs as I have requested or may request.

I agree that, using the contact information I provide, Ipsen may contact me by phone, mail, and/or email for reasons related to the IPSEN CARES program and support services, including (1) determining I am eligible for assistance and related support services, (2) leaving messages for me that disclose that I am on Tazverik therapy and/or applied for IPSEN CARES support services and am or am not eligible for assistance; (3) operating IPSEN CARES patient programs that might help me pay for or access my medicines; and (4) confirming receipt of medications. I consent to being contacted by an IPSEN CARES program representative in order for the program to obtain further information or clarification regarding any adverse event I may experience. I also give Ipsen permission to share my PHI and other information with people and companies that work with IPSEN CARES, including; government agencies, including insurance providers; my doctor(s) and other people, or institutions who are involved in my healthcare, such as pharmacies and hospitals; and/or other organizations that might help me pay for my medication. All information that I provide may be used by Ipsen or any third party working on behalf of Ipsen in connection with IPSEN CARES. I understand that my healthcare providers may receive remuneration from Ipsen in connection with my PHI and/or for any therapy support services provided to me.

I understand that once my PHI has been disclosed to Ipsen, it is no longer protected by federal privacy laws, and Ipsen may re-disclose it; however, Ipsen has agreed to make reasonable efforts to protect my PHI by using and disclosing it only for the purposes described above or as required by law. I can withdraw this authorization by contacting IPSEN CARES at 1-866-435-5677 or mailing a letter requesting such revocation to IPSEN CARES, 2250 Perimeter Park Dr. Suite 300 Morrisville, NC 27560, but it will not change any actions taken before I withdraw this authorization. Withdrawal of this authorization will end further uses and disclosures of PHI by the parties identified in this form except to the extent those uses and disclosures have been made in reliance upon this authorization.

Please see Indication and Important Safety Information on page 4 and accompanying full Prescribing Information, including Medication Guide.

Please fill out this form completely and then fax to 1-888-525-2416

STEP 2 (continued)

PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION: IPSEN CARES® PROGRAM (continued)

I understand that I may refuse to sign this form and, if I do so, I will not be able to participate in the IPSEN CARES Medication Support Nurse Program, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment, or affect my insurance enrollment or eligibility for insurance coverage.

This authorization expires three years from the date signed unless a shorter time is required by law or unless I revoke my authorization before that time. I understand that I will receive a copy of the signed authorization.

I confirm that any information that I provide to IPSEN CARES is complete and true.

I confirm that I am a resident of the United States (including its territories). I understand that Ipsen may revise, change, or terminate this program at any time without notice.

Patient/Legal Guardian Signature _____ **Date** _____

ADDITIONAL PRODUCT AND SUPPORT INFORMATION

Text Communications

To the extent that I have opted in under Step 1 of this form, I agree to be contacted by autodialed text messages ("texts") at the mobile phone number I have provided for the purpose of helping me stay on therapy, which may promote or advertise the Ipsen products included in the therapy plan, and/or which may include provision of educational materials and information about programs that support patients. I certify that the number I am providing belongs to me and not a family member or third party. I understand that I may opt out of individual communications or all text communications entirely at any time by calling 1-866-435-5677 or replying "STOP" by text to any text from Ipsen. Ipsen will not sell or rent this information and will use it only in accordance with this authorization and consent. Consent to being contacted by text messages is not a condition of participation in the IPSEN CARES Medication Support Nurse Program or the purchase of any products or services. I understand that my cellular service carrier's data and text messaging rates may apply. This authorization expires three years from the date signed unless a shorter time is required by law or unless I revoke my authorization before that time. If I am providing this consent on behalf of another person, I certify that I am authorized to agree to every element of this consent on behalf of such other person, and I agree that I will be liable and will hold Ipsen harmless in the event that such other person alleges that they did not give consent.

IPSEN CARES® MEDICATION SUPPORT NURSE PROGRAM ENROLLMENT FORM

Questions? Call IPSEN CARES at 1-866-435-5677

TAZVERIK® (tazemetostat) tablets 200 mg

INDICATIONS

What is TAZVERIK®?

TAZVERIK is a prescription medicine used to treat:

- Adults and children aged 16 years and older with epithelioid sarcoma that has spread or grown and cannot be removed by surgery.
- Adults with follicular lymphoma when the disease has come back or did not respond to treatment, whose tumors have an abnormal EZH2 gene, **and** who have been treated with at least two prior medicines. Your healthcare provider will perform a test to make sure TAZVERIK is right for you.
- Adults with follicular lymphoma when the disease has come back or did not respond to treatment, who have no other satisfactory treatment options.

The approval of TAZVERIK in these patients is based on studies that measured the percentage of patients whose tumor shrank or disappeared after treatment and how long that response lasted. TAZVERIK is still being studied to confirm these benefits.

It is not known if TAZVERIK is safe and effective in children less than 16 years of age.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about TAZVERIK?

TAZVERIK can cause serious side effects, including:

- **Risk of new cancers.** An increase in new (second) cancers has happened in people who were treated with TAZVERIK. Talk with your healthcare provider about your risk of developing new cancers. Your healthcare provider will monitor you for new cancers after your treatment with TAZVERIK. Tell your healthcare provider if you are more tired than usual, or have easy bruising, fever, bone pain, or paleness.

Before taking TAZVERIK tell your healthcare provider about all of your medical conditions, including if you:

- Are pregnant or plan to become pregnant. TAZVERIK can harm your unborn baby. Your healthcare provider will give you a pregnancy test before you start treatment with TAZVERIK. Tell your healthcare provider right away if you become pregnant or think you may be pregnant.
  - **Females** who are able to become pregnant should use effective non-hormonal birth control (such as condoms) during treatment and for 6 months after the final dose of TAZVERIK. Birth control pills (oral contraceptives) and other hormonal forms of birth control may not be effective if used during treatment with TAZVERIK. Talk to your healthcare provider about birth control options that are right for you.
  - **Males** with female partners who are able to become pregnant should use effective birth control during treatment and for 3 months after the final dose of TAZVERIK.
- Are breastfeeding or plan to breastfeed. It is not known if TAZVERIK passes into your breast milk. Do not breastfeed during treatment and for 1 week after the final dose of TAZVERIK.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. TAZVERIK may affect the way other medicines work and other medicines may affect how TAZVERIK works.

What should I avoid while taking TAZVERIK?

- Avoid eating grapefruit or drinking grapefruit juice during treatment with TAZVERIK.
- Avoid taking St. John's wort during treatment with TAZVERIK.

Talk to your healthcare provider before starting any new medications, vitamins, or herbal supplements.

What are the possible side effects of TAZVERIK?

The most common side effects of TAZVERIK in people with epithelioid sarcoma include:

- Pain
- Tiredness
- Nausea
- Decreased appetite
- Vomiting
- Constipation

The most common side effects of TAZVERIK in people with follicular lymphoma include:

- Tiredness
- Cold-like symptoms (upper respiratory infection)
- Bone and muscle pain
- Nausea
- Stomach (abdominal) pain

These are not all the possible side effects of TAZVERIK.

Call your doctor for medical advice about side effects. You may report side effects to Ipsen Biopharmaceuticals, Inc. at 1-855-463-5127 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see accompanying full Prescribing Information, including Medication Guide.

IPSEN CARES® Coverage, Access, Reimbursement & Education Support