



ENROLLMENT FORM INSTRUCTION GUIDE

Deciphera AccessPoint enrollment forms can be used to prescribe our medicines and access patient support services. Separate forms exist for QINLOCK® (ripretinib) and ROMVIMZA™ (vimseltinib).

How to Access the Enrollment Forms

You can visit DAPenroll.com to access the digital versions of the enrollment forms. Forms are also available through your territory manager.

Enrollment Form Instructions and Best Practices

Below are section descriptions and instructions for filling out the form. Sections containing **priority requirements** are denoted with **red**. Failure to complete priority fields may lead to fulfillment delays. To begin, choose the form for the product you wish to prescribe, either QINLOCK or ROMVIMZA.

SECTION 1. PATIENT INFORMATION: Required to ensure Deciphera AccessPoint has enough information to contact your patient.

SECTIONS 2 & 3. INSURANCE INFORMATION: Providing complete insurance information and attaching any relevant insurer approval or denial letters can help expedite the process.

SECTION 4. CLINICAL INFORMATION: Complete clinical context, including diagnosis and prior lines of therapy, is required.

Deciphera AccessPoint™ Enrollment Form
PLEASE COMPLETE THE ENTIRE FORM, SIGN, AND FAX IT TO 1-855-DCPH-FAX (1-855-327-4329).
Deciphera AccessPoint is a patient support service. For questions, call Deciphera AccessPoint at 1-855-DCPH-FAX (1-855-327-4329).
Access a digital enrollment form at DAPenroll.com, or e-prescribe directly to Pharmacist Pharmacy (NCPDP Number 1835191).

*Denotes a required field. Failure to fill in all required fields may lead to fulfillment delays. Clinical Trial Patient ID: _____

1. PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth (MM/DD/YYYY): _____
Gender: ☐ Male ☐ Female ☐ Other _____ Home Phone: _____ Mobile Phone: _____
Street Address: _____ City: _____ State: _____ ZIP: _____
Email (required for some educational services): _____ Preferred Contact Method: ☐ Call ☐ Email ☐ Text
Primary Language: ☐ English ☐ Spanish ☐ Other _____ Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening
Care Partner Name: _____ Care Partner Phone: _____

2. INSURANCE INFORMATION

NOTE: Please attach a copy of both sides of the patient's insurance card(s).

PRIMARY INSURANCE Coverage: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Private ☐ Other ☐ Uninsured
Insurer Name: _____ Policy Holder Name: _____ Relationship to Patient: _____
Phone: _____ Policy ID: _____ Group Number: _____ Policy Holder Date of Birth: _____
Does this patient have a separate pharmacy benefit card? ☐ Yes ☐ No

NAME OF PHARMACY BENEFITS MANAGER Policy ID: _____
Group Number: _____ BIN Number: _____ PCN Number: _____ Phone: _____

SECONDARY INSURANCE Coverage: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Private ☐ Other ☐ Uninsured
Insurer Name: _____ Policy Holder Name: _____ Relationship to Patient: _____
Phone: _____ Policy ID: _____ Group Number: _____ Policy Holder Date of Birth: _____
Does this patient have a separate pharmacy benefit card? ☐ Yes ☐ No

NAME OF PHARMACY BENEFITS MANAGER Policy ID: _____
Group Number: _____ BIN Number: _____ PCN Number: _____ Phone: _____

3. PATIENT INSURANCE STATUS

A Deciphera AccessPoint case manager will verify your patient's insurance coverage for _____ Please share any coverage information you've already obtained.

Has a prior authorization (PA) been initiated? ☐ Yes ☐ No If "yes" PA Status: ☐ Approved ☐ Denied ☐ Pending
Has an appeal been initiated? ☐ Yes ☐ No If "yes" PA Status: ☐ Approved ☐ Denied ☐ Pending
If "Approved", copay amount: \$ _____

Please attach any relevant insurer approval or denial letters.

4. CLINICAL INFORMATION

*Primary Diagnosis ICD-10: _____ Secondary Diagnosis ICD-10: _____
Please list names of prior: _____
☐ 1st line: _____ ☐ 2nd line: _____ ☐ 3rd line: _____
☐ 4th line and beyond: _____
Patient is: ☐ New to _____ ☐ Currently taking _____ start date: _____
Current Medication(s) (list all): _____
or ☐ Current Medication List Included/Attached (if applicable) ☐ Yes ☐ No
Known Drug Allergies: _____
☐ Clinical Notes Included/Attached

1-855-DCPH-FAX (1-855-327-4329) Monday-Friday 9AM-5PM ET 1-855-DCPH-FAX (1-855-327-4329) DAPenroll.com deciphera@dapenroll.com

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SECTION

Complete the entire prescription section initially to avoid requests for a Rapid Start or Bridge prescription later in the process.

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Indicate preferred pharmacy. If no preference exists, Deciphera AccessPoint will find a pharmacy contracted with your patient's insurance provider. If a prescription has already been sent to a specialty pharmacy, be sure to let us know.

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SECTIONS 8 & 9. ADDITIONAL PATIENT INFORMATION: Provide your reason for referral and patient financial information, if applicable.

How to Submit Completed Enrollment Form

