TAKEDA'S PATIENT ASSISTANCE APPLICATION

Mail: PO Box 30831 Bethesda, MD 20824
Phone: 1-888-229-8379
Fax: 1-866-467-7740

❑ **PRODUCT REFILL ONLY** See instructions on reverse side under "Section 5: Product Request"

Thank you for your participation in Takeda's Patient Assistance Program. Please provide the following information for each qualified patient applicant. **ALL FIELDS MUST BE COMPLETED.**
Please see important information on the reverse side of this form.

PATIENT SECTION

SECTION 1 PATIENT INFORMATION

❑ New Patient
❑ Renewing Patient

Patient Name: _____ Date of Birth: _____ Sex (M/F): _____

Address: _____ Apt/Unit #: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Last 4 digits of Social Security # (if applicable): _____

Parent/Guardian Name : _____
REQUIRED IF PATIENT IS YOUNGER THAN 18 YEARS

LANGUAGE PREFERENCE: ❑ English is 2nd Language Primary Language: _____

I am a currently living in the U.S. or Puerto Rico: ❑ Yes ❑ No

SECTION 2 FINANCIAL INFORMATION

INCOME INFORMATION
(Including Salary/Wages, Social Security / Social Security Disability, Pension/Retirement, and any other source of taxable income)

❑ I have attached the acceptable documentation for household income
(Acceptable documents checklist is provided on the reverse side of this form.)

NUMBER IN HOUSEHOLD (INCLUDING SELF) : _____

TOTAL ANNUAL HOUSEHOLD INCOME (ADJUSTED GROSS ANNUAL) $ _____

❑ **I ATTEST THAT I HAVE NO ANNUAL INCOME**

SECTION 3 PREVIOUS INSURANCE INFORMATION

INSURANCE STATUS: ❑ **I ATTEST I HAVE NO INSURANCE** Date of prior Insurance termination , if applicable: _____
❑ **MY INSURANCE DOES NOT COVER TREATMENT** Name of Insurance Company and Identification #: _____

IF APPLICABLE, PLEASE COMPLETE THE FOLLOWING:

Prior insurance Company: _____ Prior Insurance provided by: ❑ Medicare ❑ Medicaid ❑ Private Insurance ❑ Other: _____ ❑ Cobra EFFECTIVE DATES: _____

Identification #: _____ Telephone: _____ Fax: _____

PHYSICIAN/PHARMACY SECTION

SECTION 4 PHYSICIAN INFORMATION

Physician Name : _____ NPI# _____ Facility Name : _____

Address: _____ Unit #: _____ City: _____ State: _____ Zip: _____

Telephone : _____ Fax: _____ Contact name: _____

PHARMACY/ DISPENSING ENTITY INFORMATION

❑ Address same as Physician as above (please provide phone number below) ❑ **I have indicated the following Takeda Account # :** _____

Provider Name : _____ NPI# _____ Contact Name: _____

Address: _____ Unit #: _____ City: _____ State: _____ Zip: _____

Telephone : _____ Fax: _____

SECTION 5 PRODUCT REQUEST

❑ I certify product is for outpatient only, and the following treatment has been prescribed for this patient in a medically appropriate manner based on current standards of medical care.

PRODUCT REQUESTED: _____ PRESCRIBED DOSAGE/REGIMEN: _____

❑ **I have attached a copy of the patient's current prescription**

If your patient is prescribed VONVENDI*, please check Training Request/Waiver (check one box below)

❑ Yes, please provide my patient and/or caregiver with training on the proper self-infusion of VONVENDI*

❑ No, I or another health care provider have trained the patient and/or caregiver on the proper self-infusion of VONVENDI*

*Patients who are receiving VONVENDI for an active bleeding episode or for perioperative management of bleeding are not eligible.

Note: Hypersensitivity reactions have occurred with VONVENDI. In order to ensure that your patient has access to appropriate emergency treatment; we ask that the patient have epinephrine on hand.

PLEASE NOTE: THREE SIGNATURES ARE REQUIRED

- I certify that the information I have provided on this form is complete and accurate to the best of my knowledge
- I also certify that I do not have sufficient financial resources to pay for the medication requested, of that paying for these medications from my own resources would cause me financial hardship.
- I understand that Takeda reserves the right to modify or terminate this program at any time, or to refuse to distribute Takeda treatments under this program to any patient or provider.
- I understand that the information provided above is being used solely to determine my eligibility for product assistance through Takeda's Patient Assistance Program (Program) and my personal information, including name, address, phone number, email address, and information related to health insurance and treatment, may be shared with Takeda and companies working with Takeda for the purpose of administering this program.
- **I understand that at such time that I obtain prescription coverage or have the financial resources to pay for the cost of my treatment, I will notify the Program administrator of such a change in my coverage status within 7 days.**

PATIENT SIGNATURE (REQUIRED): _____ DATE: _____

- I certify that the information I have provided on this form is complete and accurate to the best of my knowledge
- I understand that acceptance into this Program requires that my eligible patient complete and sign a confidentiality and release of information form to allow Takeda and the insurance support administrator access to necessary medical and insurance records. I agree to explain to my patient the consent being requested and to obtain the necessary medical and insurance documents.
- I agree to allow the Program administrator to review the medical and insurance records as part of the Program as necessary for the purpose of verifying the patient's medical and insurance status.
- I understand that Takeda reserves the right to modify or terminate this program at any time, or to refuse to distribute Takeda treatments under this program to any patient or provider.
- I agree to maintain a copy of this form and to furnish a copy to the Internal Revenue Service or other government agencies upon request.
- I certify that the Takeda treatments sent by Takeda under this program will be provided to my enrolled and program-eligible patients free of charge. No federal or state healthcare program, private payer, or patient will be charged for the free product, and no free product will be distributed for sale to any individuals, or used by any other individuals.
- If I become aware of any changes in my eligible patient's circumstances that would affect his or her eligibility, or any changes that affect my eligibility to act as an authorized dispensing entity, I agree to immediately notify the Program administrator.
- I certify that the product shipped by Takeda Pharmaceuticals Company Limited under this program will be given to the patient indicated, free of charge. No third party or patient will be charged for the free units, and no free units will be distributed for sale to any individuals. In addition, I represent that the information contained in this form is complete and accurate to the best of my knowledge and agree to notify the Program administrator of any changes I become aware of that would affect the eligibility status of the patient.
- I understand that the information provided on this form will be used solely for purposes of facilitating product shipment on behalf of my eligible patient.

PHARMACY SIGNATURE (REQUIRED): _____ DATE: _____

PHYSICIAN SIGNATURE (REQUIRED): _____ DATE: _____

HEMATOLOGY PATIENT ASSISTANCE PROGRAM

Patient Authorization to Share Personal Health Information

By signing this Patient Authorization, I authorize my physician, health insurance, and pharmacy providers (including any specialty pharmacy that receives my prescription) to disclose my protected health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form ("Protected Health Information"), to Takeda Pharmaceuticals U.S.A., and its present or future affiliates, including the affiliates and service providers that work on Takeda's behalf (the "Companies") in connection with the Takeda Hematology Patient Assistance Program (the "Program"). The Companies will use my Protected Health Information for the purpose of facilitating the provision of the Program. Specifically, I authorize the Companies to receive, use, and disclose my Protected Health Information in order to enroll me in the Program and contact me, and/or the person legally authorized to sign on my behalf, about the Program.

I understand that employees of the Companies only see my Protected Health Information to administer the Program or as otherwise required or allowed under the law, unless information that specifically identifies me is removed. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, my Protected Health Information disclosed under this Authorization may no longer be protected by federal privacy law. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Policy available at https://www.takeda.com/privacy-notice. I understand that such cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from the date it is signed, unless a shorter period is provided for by state law. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way my physician, health insurance, and pharmacy providers treat me. I also understand that if I do not sign this Authorization, I will not be able to receive support through the Program.

PATIENT SIGNATURE (REQUIRED): _____ DATE: _____

Legal Representative Name and Relationship to Patient (if applicable): _____

Legal Representative Signature: _____ DATE: _____

TAKEDA'S PATIENT ASSISTANCE APPLICATION

PATIENT SECTION

PHYSICIAN/PHARMACY SECTION

Application for Patient Assistance

Thank you for your participation in Takeda's Patient Assistance Program which provides Takeda product at no cost to patients who meet all program eligibility criteria as follows:

- The patient must be currently living in the United States or Puerto Rico with a physical mailing address (shipping to P.O. Boxes is prohibited). Proof of citizenship is not required.
- The patient must have no health insurance coverage at the time of application.
- The patient must meet the program's financial eligibility guidelines which vary by household size.

SECTION 1: PATIENT INFORMATION

Please provide the requested information for each qualified patient applicant. ALL FIELDS MUST BE COMPLETED. Failure to complete required information will delay the review process.

SECTION 2: FINANCIAL INFORMATION

Please provide the most recent copy of any one of the following acceptable documents FOR ALL IDENTIFIED IN TOTAL ADJUSTED HOUSEHOLD INCOME.

- ❑ US Income Tax Form 1040 or 1040EZ
- ❑ Two (2) Pay Stubs
- ❑ W-2 Form
- ❑ Social Security Benefit Statement
- ❑ Social Security Disability Statement
- ❑ Statements of interest, dividends, or other income (1099-INT, 1099, 1099-DIV, or similar forms)

For patients with no documentation supporting attestation of No Annual Income, please provide a signed copy of IRS Form 4506-T (Request for Transcript of Tax Return) or contact Takeda's Patient Assistance Program at 888-229-8379.

SECTION 3: PREVIOUS INSURANCE INFORMATION

Please provide copies of all previous insurance card(s) as applicable.

SECTION 4: PHYSICIAN INFORMATION/PHARMACY INFORMATION

Please be sure to complete all fields in order to process application.

SECTION 5: PRODUCT REQUEST

Please be sure to provide a copy of patient's current prescription for Takeda product requested, in order to process application. For PRODUCT REFILL ONLY, the following are required: (a) completion of Section 1, (b) completion of Section 4, and (c) Physician Signature at bottom of the application. Please update any information which may have changed since initial approval in Section 2, 3, or 5.

SUBMISSION

Upon completion, please make a photocopy of your enrollment form and income documentation for your records. By mail or fax, submit Takeda's Patient Assistance Program application form and all corresponding documents to the:

Takeda's Patient Assistance Program
PO Box 30831
Bethesda, MD 20824
Fax: 1-866-467-7740

Upon receipt of a completed application, the physician and patient will be notified of eligibility and approval.

If you have any questions, please contact our program at 1-888-229-8379 to speak with a program representative.

The information you provide will be used to administer support services and information on Takeda's programs, therapies, and services to you and your patient. We may share the information provided with our partners who facilitate the verification and delivery of this information. If you ever decide that you do not wish to receive information from us regarding our therapies and services, contact us at: Consumer Relations, Takeda, 1200 Lakeside Drive, Bannockburn, IL 60015 or at 800-241-9360. If you have any questions, comments, concerns, or complaints about our information practices, call 1-844-229-2582 (U.S.) or 224-940-5832 (outside of the U.S.), fax your inquiry to 224-940-5833, or send us mail at Takeda, 1200 Lakeside Drive, Bannockburn, IL 60015.

This form is designed to facilitate the compliance of HIPAA as well as other privacy laws.

US-XMP-2450v1.0 05/23