Takeda Oncology Here2Assist

Takeda Oncology Patient Assistance Program

The Takeda Oncology Patient Assistance Program* is here to help

If your patient is uninsured or the prescribed medication is not covered, the Takeda Oncology Patient Assistance Program (PAP) may be able to provide eligible patients with a monthly supply of **ALUNBRIG® (brigatinib), ICLUSIG® (ponatinib),** or **NINLARO® (ixazomib)** at no cost to them. Patients must meet certain financial and insurance coverage criteria to be eligible.

Please see accompanying ICLUSIG® full Prescribing Information, including Boxed Warning.

Phyllis
Takeda Oncology Here2Assist™ patient

For more information, call us at 1-844-817-6468, Option 2, or visit www.Here2Assist.com. **Let's Talk.** We're available Monday-Friday, 8AM-8PM ET.

*Terms and Conditions apply.

Hans
Takeda Oncology
Here2Assist patient

Takeda Oncology Here2Assist

Takeda Oncology Patient Assistance Program

How to enroll a patient in the Takeda Oncology Patient Assistance Program*:

1. **COMPLETE** this application form in its entirety together with your patient. Use the checklist below to ensure all required information on the form is complete:

1. ❑ Select Product
2. ❑ Prescriber Information
3. ❑ Patient Information
4. ❑ Patient Authorization (original signature required)
5. ❑ Patient Current Insurance Information
6. ❑ Statement of Medical Necessity
7. ❑ Patient Financial Information (income verification)
8. ❑ Prescriber Authorization (original signature required)
9. ❑ Valid Prescription (must be faxed with application)

2. **SIGN AND DATE** the form. Patient (or patient representative) and prescriber authorization is required in the form of an original signature following review of the patient authorization and the prescriber authorization sections.

IMPORTANT: Original signatures are required.
Please ensure original signatures for the prescriber and patient are applied. Stamped signatures will not be accepted. Applications that do not include original signatures cannot be processed, and your patient's enrollment may be delayed.

3. **FAX** the completed and signed application form along with a **valid prescription** to Takeda Oncology Here2Assist™ at 1-844-269-3038.

IMPORTANT: Prescription is only valid if received by fax.

NOTE: Please do not send patient medical records or any other documentation that has not been requested.

What to expect after enrollment

If your patient qualifies, he or she may be enrolled for up to 1 year. Upon enrollment, a Takeda Oncology Here2Assist case manager will notify you and your patient. A 1-month supply of medication will be delivered to your patient at no cost to them. Each month, a Takeda Oncology Here2Assist case manager will confirm with you and your patient that he or she is still being treated and is eligible to receive another month's supply of medication.

For more information, call us at 1-844-817-6468, Option 2, or visit www.Here2Assist.com.
Let's Talk. We're available Monday-Friday, 8AM-8PM ET.

*To be eligible for the Patient Assistance Program, patients must meet certain financial and insurance coverage criteria. A Patient Assistance Program Application must be submitted in order to confirm patient eligibility.

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Takeda Oncology Patient Assistance Program

Fax to 1-844-269-3038 or **call** 1-844-817-6468, Option 2, Mon-Fri, 8AM-8PM ET

PRODUCT (select one) ☐ ALUNBRIG® (brigatinib) ☐ ICLUSIG® (ponatinib) ☐ NINLARO® (ixazomib)

Please see accompanying ICLUSIG® full Prescribing Information, including Boxed Warning.

PRESCRIBER INFORMATION

Name (First, Middle, Last): _____ Practice Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Primary Office Contact: _____

State License #: _____ NPI: _____ Medicaid/Medicare Provider #: _____ Reimbursement Contact: _____

PATIENT INFORMATION

Name (First, Middle, Last): _____ Date of Birth (MM/DD/YYYY): _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ OK to leave message? ☐ Yes ☐ No Email: _____

PATIENT AUTHORIZATION FOR TAKEDA ONCOLOGY HERE2ASSIST™

I understand that Takeda Oncology Here2Assist is a prescription assistance service offered by Millennium Pharmaceuticals Inc. ("Takeda") to help eligible patients who have been prescribed Takeda Oncology medication obtain financial assistance and access other patient support programs provided by Takeda Oncology Here2Assist.*

I authorize my healthcare providers, pharmacy, and health plans to share my personal and medical information, including information about my insurance, prescriptions, medical condition, and health ("Protected Health Information") with and between Takeda and its present or future affiliates, including the affiliates and service providers that work on behalf of Takeda Oncology Here2Assist (together the "Takeda Group"), to: 1) obtain information on insurance coverage for my medication indicated by my prescribing physician above; 2) establish my eligibility for benefits from my health plan or other programs, upon request; 3) coordinate prescription fulfillment of my medication as indicated by my prescribing physician above; 4) facilitate my access to Takeda Oncology Here2Assist and additional patient support programs provided by Takeda Oncology Here2Assist; 5) manage Takeda Oncology Here2Assist and additional patient support programs provided by Takeda Oncology Here2Assist; 6) provide me with adherence reminders and support; 7) contact me to evaluate the effectiveness of Takeda Oncology Here2Assist and other patient support programs provided by Takeda Oncology Here2Assist; 8) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Takeda Oncology Here2Assist and additional patient support programs provided by Takeda Oncology Here2Assist, or other Takeda Oncology products and services; and 9) contact me for Takeda's internal business purposes, including quality control and assessment in connection with Takeda Oncology Here2Assist and other patient support programs provided by Takeda Oncology Here2Assist, as well as other Takeda Oncology products and services.

I understand that my pharmacy, health insurers, and third-party vendors may receive remuneration (payment) from the Takeda Group in exchange for processing my Protected Health Information to facilitate prescription assistance service, financial assistance, and/or for providing me with access to support services for the purposes described in this Patient Authorization.

I understand that once my Protected Health Information is disclosed, it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 1-844-817-6468 or by writing PO Box 4280, Gaithersburg, MD 20885-4280. If I do not sign this authorization, I understand my eligibility for health plan benefits and treatment by my doctor will not change, but I will no longer be eligible to participate in Takeda Oncology Here2Assist, or additional patient support programs provided by Takeda Oncology Here2Assist, or other Takeda Oncology programs and services. If I revoke this authorization, the Takeda Group will stop using or sharing my Protected Health Information (except as necessary to end my participation in Takeda Oncology Here2Assist), but my revocation will not affect uses and disclosures of my Protected Health Information previously disclosed in reliance on this authorization. I understand that this written authorization will remain valid for 5 years from the date of my signature, unless I revoke it earlier, or unless a shorter period is required under state laws. I understand that I may receive a copy of this authorization. *Restrictions apply.

SIGN HERE **Patient Signature:** _____ Date: _____

Takeda Oncology Here2Assist

Takeda Oncology Patient Assistance Program

Fax to 1-844-269-3038 or **call** 1-844-817-6468, Option 2, Mon-Fri, 8AM-8PM ET

The following information will be used to determine patient eligibility. Patients must meet certain financial and insurance coverage criteria. Please do not send patient medical records or any other documentation that has not been requested.

CURRENT INSURANCE INFORMATION

Please attach copies of both sides of the patient's insurance card(s). Include both medical and pharmacy information if available.

Insurance Plan: ❑ Medicare ❑ Medicaid ❑ Private/Commercial ❑ Other _____

Primary Insurer Name: _____ Insurer Phone: _____

Policy Holder Name (First, Middle, Last): _____ Policy Holder Date of Birth (MM/DD/YYYY): _____

Policy ID #: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

Secondary Insurer Name: _____ Insurer Phone: _____

Policy Holder Name (First, Middle, Last): _____ Policy Holder Date of Birth (MM/DD/YYYY): _____

Policy ID #: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

❑ Patient has no insurance ❑ Patient's insurance is pending with (include name of insurer here): _____

❑ Valid prescription attached (must be faxed with application)

STATEMENT OF MEDICAL NECESSITY

ICD-10 Code: _____

FINANCIAL INFORMATION

Financial Information: Income documentation attached (1040 IRS Forms, SSI Letter, SSDI, Unemployment, Workers' Compensation, etc.) ❑ Yes ❑ No

Size of Household (including patient): _____ Annual Gross Household Income: _____

AUTHORIZATION

By signing this form, I certify that the information provided above is current, complete, and accurate to the best of my knowledge. I certify that the prescribed Takeda Oncology medication is medically necessary for this patient and that I have exercised my independent medical judgment in writing this prescription for the patient above. I further certify that I shall not seek reimbursement or credit from any insurer, healthcare plan, or government program nor will I attempt to sell, barter, or return for credit any Takeda Oncology medication provided under this program. I understand that I am under no obligation to prescribe or purchase the prescribed medication or any other product manufactured by Takeda, and I certify I have received nothing of value from Takeda or its agents or representatives for prescribing a Takeda product.

SIGN HERE **Prescriber Signature:** (no stamp allowed) _____ Date: _____

ATTENTION New York State Prescribers: Prescribers in New York State must submit prescription on an original NY State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank if applicable for your state.

NOTE: Patient Authorization is required to enroll in Takeda Oncology Here2Assist™. If Patient Authorization is not obtained prior to submission of enrollment form, the prescriber authorizes Takeda to email Patient for completion.

By signing this form and accepting the benefits of the program, I certify that the information I have provided on this form, including information related to my income and insurance status, is truthful and complete. I understand that Takeda, or a vendor used by Takeda to carry out the Patient Assistance Program (PAP), may contact me to verify any information I have provided and that my participation in the program will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I certify I will not seek reimbursement or credit from any private insurer or government healthcare program for the Takeda Oncology medication provided under the PAP, nor will I sell or trade the Takeda Oncology medication provided under the PAP. If I am enrolled in a Medicare Part D plan, I certify that I will not attempt to have this prescription or any cost associated with it counted as any portion of my true out-of-pocket ("TrOOP") calculations. I acknowledge and understand that I am under no obligation whatsoever to purchase my prescribed Takeda Oncology medication or any other product manufactured by Takeda either before or after the prescribed Takeda Oncology medication is provided to me under the PAP. I understand that Takeda may modify or end the PAP at any time.

SIGN HERE **Patient Signature:** _____ Date: _____

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