Help At Hand

Patient Assistance Within Reach

Takeda Patient Assistance Program
P.O. Box 5727, Louisville, Kentucky 40255-0727
Phone: 1-800-830-9159 Fax: 1-800-497-0928

CAN I APPLY?

At Takeda, we believe all patients should have access to the medications prescribed by their healthcare providers. We also understand that some patients may have financial situations that make it difficult to pay for their prescriptions. Help At Hand (the Program) provides assistance for people who have no insurance or who do not have enough insurance and need help getting their Takeda medicines. All applications are reviewed on a case-by-case basis in accordance with program criteria.

To be eligible, you should:

- ❑ Be a resident in the United States
- ❑ Not have health coverage, or not have enough coverage to obtain your Takeda medication
- ❑ Have a household income equal to or less than 5 times the Federal Poverty Level (for more information on Federal Poverty Levels, visit http://www.aspe.hhs.gov/poverty/index.cfm)
- ❑ Not have access to alternate sources of coverage or funding
- ❑ Have recently lost your job and experiencing financial hardship

CHECKLIST FOR SUBMITTING APPLICATION

- ❑ Complete Sections 1, 4, 5, and 6, including signatures
- ❑ Attach current proof of income as outlined in Section 4
- ❑ Have healthcare provider complete and sign Sections 2 and 3
- ❑ Fax or mail the completed application and all documentation to the address above

Prescription must be faxed in from healthcare provider

SECTION 1: PATIENT INFORMATION

First Name: Last Name:

Home Address: City: State: ZIP Code:

Preferred Daytime Phone Number:

Date of Birth *(MM/DD/YYYY)*: ❑ Male ❑ Female

U.S. Resident: ❑ Yes ❑ No

Deliver Medication To: ❑ Patient ❑ Healthcare Provider *(Delivery will be to patient unless otherwise indicated.)*

IMPORTANT: Please go to next page. Call 1-800-830-9159 if you need help. Patient Assistance Program representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. ET

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK

Patient Name: DOB:

SECTION 2: HEALTHCARE PROVIDER INFORMATION

Last Name:	First Name:	Phone:	Fax:
Address:	City:	State:	ZIP Code:
State License Number:	DEA# *(if prescribing a controlled substance)*:		

SECTION 3: PRESCRIPTION INFORMATION
(NJ and NY physicians please attach appropriate prescription)

Allergies:

Current Medications:

Product *(Please select and complete ship product to below)*	**Dosage**	**Directions**	**Distribution**	**Refills** *(please select)*
❑ AMITIZA® (lubiprostone)	❑ _____ mcg	_____	☑ 90-day supply	○1 ○2 ○3
❑ Carbatrol® (carbamazepine) Extended-Release Capsules	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ COLCRYS® (colchicine, USP) Tablets	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ DEXILANT® (dexlansoprazole)	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ INTUNIV® (guanfacine) Extended-Release Tablets	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ FOSRENOL® (lanthanum carbonate) Chewable Tablets	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ FOSRENOL®(lanthanum carbonate) Oral Powder	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ KAZANO® (alogliptin and metformin HCl)	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ Lialda® (mesalamine) Delayed-Release Tablets	❑ _____ g	_____	☑ 90-day supply	○1 ○2 ○3
❑ Motegrity™ (prucalopride) Tablets	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ Mydayis® (mixed salts of a single-entity amphetamine product) Extended-Release Capsules CII	*Pharmacy pick up physician must provide a prescription*		☑ Pharmacy Card	○1 ○2 ○3
❑ NESINA® (alogliptin)	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ OSENI® (alogliptin and pioglitazone)	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ PENTASA® (mesalamine) Controlled-Release Capsules	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ PREVACID SOLUTAB® (lansoprazole) delayed-release orally disintegrating tablets)	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ ROZEREM® (ramelteon)	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ TRINTELLIX® (vortioxetine)	❑ _____ mg	_____	☑ 90-day supply	○1 ○2 ○3
❑ Vyvanse® (lisdexamfetamine dimesylate) Capsules CII	*Pharmacy pick up physician must provide a prescription*		☑ Pharmacy Card	○1 ○2 ○3
❑ Vyvanse® (lisdexamfetamine dimesylate) Chewable Tablets CII	*Pharmacy pick up physician must provide a prescription*		☑ Pharmacy Card	○1 ○2 ○3

Ship Product to ❑ Physician's Office ❑ Patient's Address (*If no selection is made, product will be shipped to Patient's Address*)

My signature certifies that prescribed therapy is medically necessary for the subject patient and that I will be supervising the patient's treatments. I certify that the information provided by me on this application is true and accurate. Additionally, I certify that if the product is sent to my office on behalf of the patient, I understand that it must be used for the patient listed on this application, and not be resold or offered for sale or trade, nor shall the patient nor any third-party payer, Medicare or Medicaid be charged for this product.

Healthcare Provider Signature *(Stamped Signatures NOT ACCEPTED)*

SIGN **X** **Date:**

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Patient Name: DOB:

SECTION 4: INSURANCE AND INCOME

Do you have prescription drug insurance from: *(check all that apply)*

❑ None ❑ VA/Military benefits ❑ Health exchange plan ❑ Employer supplied/private coverage

❑ Medicare Part D (Part D ID number: _____) ❑ Medicaid

Number of people in household* **Household = you, spouse and dependents*

Total yearly household* income: $

Have you received Social Security Disability Income for at least two years? ❑ Yes ❑ No

To verify your income, please include a copy of one of the following:

❑ Last year's federal income tax return(s) for yourself, your spouse and your dependents

❑ Social Security Yearly Benefits Statement (SSA-1099) or

❑ All household income statements from the last month

❑ Have you recently lost your job and are experiencing financial hardship? ❑ Yes ❑ No ❑ If Yes, please attach proof of job termination or unemployment.

If these documents do not accurately reflect your current financial status, please send documentation of your current income or unemployment.

SECTION 5: PATIENT DECLARATIONS

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW

1. The information provided by me on this application form is true and accurate;
2. I give consent to the Program to disclose my enrollment in the Program as needed to comply with legal and regulatory obligations;
3. I agree to notify the Program immediately, in writing, if my prescription drug coverage changes in any way or if I discontinue use of the requested medication;
4. I will not seek or accept reimbursement from any health or prescription coverage plan, including a Medicare plan, for medication received from the Program;
5. I understand that if I am eligible or enrolled in a Medicare plan, I will
   a) receive the requested medication from the Program for the remainder of the enrollment calendar year for which my application was approved, and I will not seek the requested medication from my Medicare plan for the remainder of the enrollment calendar year;
   b) not seek true out-of-pocket (TrOOP) credit for any medication received from the Program because I understand that medication received from the Program will not count toward my TrOOP; and
   c) agree to notify my Medicare plan that I will receive my Takeda medication for free until the end of the year through the Program;

Patient Signature/Legal Representative (*indicate relationship*)

SIGN **X** **Date:**

Takeda does not charge patients a fee for its assistance. Takeda is not affiliated with third parties who charge a fee for assistance with enrollment or medication refills. If you are being charged a monthly fee for support from Takeda, the organization billing you is not Takeda and you are being charged for support that Takeda can provide to you directly at no cost.

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SECTION 6: PATIENT AUTHORIZATION
PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN BELOW

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 Help At Hand 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 www.takeda.us/home/privacy_policy.aspx. 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/Legal Representative (*indicate relationship*)

SIGN **X** _____ **Date:** _____

Patient Name: _____ DOB: _____

What happens next? You and/or your healthcare provider will receive an answer from the Takeda Patient Assistance Program within five to seven days after we receive your application. **Please call 1-800-830-9159 if you have questions.** Representatives are available Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. Quantity of bottles supplied may vary based on patient prescription.

This program, as well as all Takeda Pharmaceuticals America, Inc. programs, can be discontinued or changed at any time without notice at the discretion of Takeda Pharmaceuticals America, Inc.

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