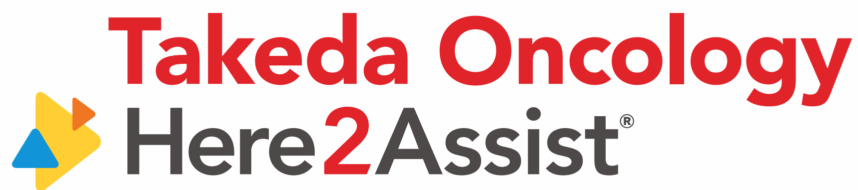


Enrollment Form

Questions about enrolling in our support program? **We have the answers.**

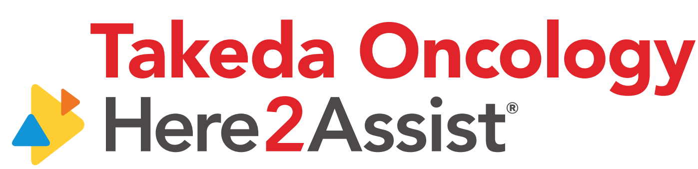
Let's Talk. Call us at 1-844-817-6468, Option 2.
We're available Monday-Friday, 8AM-8PM ET.

www.Here2Assist.com

Daryl
Takeda Oncology
Here2Assist® patient

Takeda Oncology Here2Assist® is a comprehensive support program committed to helping patients navigate coverage requirements, identify available financial assistance, and connect with helpful resources throughout their treatment. Patients who are prescribed **ALUNBRIG® (brigatinib)**, **FRUZAQLA™ (fruquintinib)**, **ICLUSIG® (ponatinib)**, or **NINLARO® (ixazomib)**, are eligible to enroll in this program.

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



Enrollment Form

How to enroll a patient in Takeda Oncology Here2Assist®

1. **COMPLETE ALL INFORMATION** in its entirety with your patient, including product selection, prescriber information, patient information, current insurance information, statement of medical necessity, pharmacy preference, and prescription request.

2. **SIGN AND DATE** the form. Prescriber and patient (or legal representative) authorization is required in the form of an original signature following review of the prescriber authorization and the patient authorization sections. A patient's (or legal representative's) original signature is also required on the program enrollment section.

   IMPORTANT: Original signatures are required.
   Please ensure original signatures for the prescriber and patient (or legal representative) 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 form along with a copy of your patient's insurance card and prescription to Takeda Oncology Here2Assist at 1-844-269-3038.

   IMPORTANT: The prescription is only valid if received by fax.

What to expect after enrollment

After your patient's enrollment form is received and processed, a Takeda Oncology Here2Assist case manager will conduct a benefits verification to determine the patient's prescription coverage and potential out-of-pocket costs. A benefits verification will be completed by Takeda Oncology Here2Assist within 2 business days.*

Takeda Oncology Here2Assist offers additional support

For patients who experience a delay in coverage determination, are uninsured, or have insurance but are not covered for the prescribed medication, Takeda Oncology Here2Assist may offer additional support. Learn more about the **Patient Assistance Program**† and the **RapidStart Program**† at **www.Here2Assist.com** or call **1-844-817-6468**, Option 2.

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.**

*Verification of benefits is not a guarantee of payment and does not take the place of written policy information.
†Separate program enrollment is required. Terms and Conditions apply.

Takeda Oncology Here2Assist®

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

Enrollment Form

PRODUCT (please select one)

Is the patient hospitalized? ■ Yes ■ No

❑ **ALUNBRIG®** (brigatinib) ❑ **NINLARO®** (ixazomib)
❑ **ICLUSIG®** (ponatinib) ❑ **FRUZAQLA™** (fruquintinib)

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: ______ Medicare/Medicaid Provider #: ______ Reimbursement Contact: ______

PATIENT INFORMATION

Name (First, Middle, Last): ______ Preferred Name: ______
Preferred Language: ______ Date of Birth (MM/DD/YYYY): ______ Gender*: ❑ Male ❑ Female
Address: ______ City: ______ State: ______ ZIP: ______
Phone: ______ OK to leave a message? ❑ Yes ❑ No Email: ______
Mobile: ______ OK to leave a message? ❑ Yes ❑ No

CARE PARTNER INFORMATION

Please complete this section if you would like Takeda Oncology Here2Assist® to communicate about the program primarily with your care partner on your behalf.

Name: ______ Relationship: ______
Phone: ______ OK to leave a message? ❑ Yes ❑ No Email: ______
Mobile: ______ OK to leave a message? ❑ Yes ❑ No

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 Type: ❑ Medicare ❑ Medicaid ❑ Private/Commercial ❑ Other: ______

Does your patient have Veterans Administration benefits? ❑ Yes ❑ No Does your patient belong to a federally recognized tribe? ❑ Yes ❑ No

Is your patient on disability? ❑ Yes ❑ No Does your patient have Medicare? ❑ Yes ❑ No

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): ______

Visit www.Here2Assist.com to learn how the RapidStart Program may help eligible patients experiencing a delay in insurance coverage determination.

*Takeda and its partners recognize that patients may not identify as male or female. However, many insurance companies still require that one of the fields be used for each of their members. Please indicate the gender on file with the patient's insurance company.

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

Enrollment Form

STATEMENT OF MEDICAL NECESSITY

ICD-10 Code:____

PHARMACY PREFERENCE (select one)

❑ Specialty Pharmacy Name:________________________________ ❑ In-office dispensing ❑ No pharmacy preference

For a list of Takeda Oncology Here2Assist® network specialty pharmacies, visit **www.Here2Assist.com/hcp/distribution-and-fulfillment**.

PRESCRIPTION REQUEST: To permit medication to be sent to your patient, the prescription information must be complete and accurate.

Patient Name (First, Middle, Last):________________________ Patient Date of Birth (MM/DD/YYYY):____________

PRODUCT (select one)	DOSAGE	DIRECTIONS	DISPENSE	REFILLS (please select)
❑ **ALUNBRIG® (brigatinib) tablets**	**Initiation pack (for new patient starts only)** ❑ **90 mg orally once daily for 7 days, then 180 mg orally once daily for 23 days.** ***Fill out dosing instructions for subsequent brigatinib refills below.***			
	Subsequent refills ____ **mg**		____ -day supply	❑ 1 ❑ 2 ❑ 3 ❑ Other ____
❑ **FRUZAQLA™ (fruquintinib) capsules**	____ mg		____ -day supply	❑ 1 ❑ 2 ❑ 3 ❑ Other ____
❑ **ICLUSIG® (ponatinib) tablets**	____ mg		____ -day supply	❑ 1 ❑ 2 ❑ 3 ❑ Other ____
❑ **NINLARO® (ixazomib) capsules**	____ mg		____ -day supply	❑ 1 ❑ 2 ❑ 3 ❑ Other ____

PRESCRIBER AUTHORIZATION

I certify that the above treatment is medically necessary and the information provided is current, complete, and accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Takeda and its employees or agents to assist the patient in obtaining coverage for the above-prescribed treatment and/or to assist the patient in initiating or continuing the above-prescribed treatment. I certify that the prescription complies with all applicable local and state laws. I authorize Takeda Oncology Here2Assist to convey this prescription to the dispensing pharmacy.

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

ATTENTION New York State Prescribers: Prescribers in New York State must submit the prescription on an original New York 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 the enrollment form, the prescriber authorizes Takeda to email the patient for completion.

Takeda Oncology Here2Assist®

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

Enrollment Form

PATIENT AUTHORIZATION FOR TAKEDA ONCOLOGY HERE2ASSIST®

I understand that Takeda Oncology Here2Assist is a prescription assistance service offered by Takeda Pharmaceuticals U.S.A., 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 501847, San Diego, CA 92150-1847. 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, Takeda 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 a shorter period is required under state laws. I understand that I may receive a copy of this authorization.

*Restrictions apply.

I certify that I am the patient signing this form.

SIGN HERE **Patient Signature:** ______________________ **Date:** ________

I certify that I have been personally selected by the patient as their legal representative.

Legal Representative Signature: ______________________ **Relationship:** ________ **Date:** ________

Takeda Oncology Here2Assist®

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

Enrollment Form

TAKEDA ONCOLOGY HERE2ASSIST® MARKETING CONSENT

I have read, understand, and agree to the use of my personal information for the purposes described below.

❑ Check this box if you wish to enroll in text message communication, as described below

I authorize the use of my personal information for Takeda marketing activities and consent to receiving marketing and promotional communication from Takeda. I further authorize the program to de-identify my health information and use it in performing research, including linkage with other de-identified information the program receives from other sources, education, business analytics, marketing studies, or for other commercial purposes. I herby give consent to Takeda, its affiliates, and their agents and representatives to send communications and information to me via the contact information I have provided. Automatic dialing may be used. Carrier, text, and data rates may apply. I understand that I am not required to provide this consent as a condition of purchasing any goods or services.

I certify that I am the patient signing this form.

SIGN HERE

Patient Signature: ______________________________ **Date:**__________

I certify that I have been personally selected by the patient as their legal representative.

Legal Representative Signature:______________________________ **Relationship:** __________ **Date:**__________

TERMS AND CONDITIONS FOR THE TAKEDA ONCOLOGY HERE2ASSIST TEXTING PROGRAM

By agreeing to these Takeda Oncology Here2Assist (the "Program") text message Terms and Conditions, you agree to receive text messages on your mobile device subject to the Terms and Conditions described below. You also consent to text messages from or on behalf of the Program at the telephone number provided. You understand that this consent is not a condition of purchase or use of the Program or of any Takeda Oncology product or service.

Participants will receive text message reminders and status updates while enrolled in the Program. Such messages may be nonmarketing messages related to the Patient Assistance Program.

There is no fee payable to Takeda to receive text messages; however, your carrier's message and data rates may apply.

You represent that you are the account holder for the mobile telephone number(s) that you provide to opt into the Program. You are responsible for notifying Takeda immediately if you change your mobile telephone number. You may notify Takeda of a number change by calling 1-844-817-6468, Option 2, Monday-Friday, 8AM-8PM ET.

Data obtained from you in connection with your registration for, and use of, this SMS service may include your phone number and/or email address, related carrier information, and elements of pharmacy claim information and will be used to administer this Program and to provide Program benefits such as information about your prescription, refill reminders, as well as Program updates and alerts.

Takeda will not be liable for any delays in the receipt of any SMS messages as delivery is subject to effective transmission from your network operator.

This Program is valid with most major US carriers, including Verizon Wireless, Sprint, Nextel, Boost Mobile, T-Mobile, AT&T, Alltel, ACS Wireless, Bluegrass Cellular, Carolina West Wireless, Cellcom, Cellular One of East Central Illinois (ECIT), Cincinnati Bell, Cricket, C-Spire Wireless, Duet IP (AKA Max/Benton/Albany), Element Mobile, Epic Touch, GCI Communications, Golden State, Hawkeye (Chat Mobility), Hawkeye (NW Missouri Cellular), Illinois Valley Cellular (IVC), Inland Cellular, iWireless, Keystone Wireless (Immix/PC Management), MetroPCS, MobiPCS, Mosaic, MTPCS/Cellular One (Cellone Nation), Nex-Tech Wireless, nTelos, Panhandle Telecommunications, Pioneer, Plateau, Revol Wireless, Rina-Custer, Rina-All West, Rina-Cambridge Telecom Coop, Rina-Eagle Valley Comm, Rina-Farmers Mutual Telephone Co, Rina-Nucla Nutria Telephone Co, Rina-Silver Star, Rina-South Central Comm, Rina-Syringa, Rina-UBET, Rina-Manti, Simmetry, South Canaan/CellularOne of NEPA, Thumb Cellular, Union Wireless, United Wireless, U.S. Cellular, Viaero Wireless, Virgin Mobile, and West Central Wireless (includes Five Star Wireless).

Takeda may be required to contact the user if an adverse event is reported.

You agree to indemnify Takeda and any third parties texting on its behalf in full for all claims, expenses, and damages related to or caused, in whole or in part, by your failure to immediately notify the Program if you change your telephone number, including but not limited to all claims, expenses, and damages related to or arising under the Telephone Consumer Protection Act.

Takeda reserves the right to rescind, revoke, or amend the Program without notice at any time.

You can unsubscribe from this Program by texting STOP. For questions, call Takeda Oncology Here2Assist at 1-844-817-6468, Option 2, Monday-Friday, 8AM-8PM ET.

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