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)**, **FRUZAQLA™ (fruquintinib), 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 ALL INFORMATION** in its entirety 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 Financial Information (income verification)†
5. ❑ Patient Current Insurance Information
6. ❑ Statement of Medical Necessity
7. ❑ Patient Authorization (original signature required)
8. ❑ Prescriber Authorization (original signature required)

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 in 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 application form along with a **valid prescription** to Takeda Oncology Here2Assist® at 1-844-269-3038.

IMPORTANT: The 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, they 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 your patient that they are still being treated and 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.

†To allow for quicker processing, Takeda Oncology Here2Assist can perform an electronic income verification. This will have NO effect on your credit score/rating. This information will be used solely for the purpose of determining financial qualifications for the Takeda Oncology Patient Assistance Program.

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PRODUCT (please select one)

Is the patient hospitalized? ■ Yes ■ No

- ❑ ALUNBRIG® (brigatinib)
- ❑ FRUZAQLA™ (fruquintinib)
- ❑ 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: _____ 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

FINANCIAL INFORMATION

Financial Information: Income documentation attached (Most recent IRS form 1040, W-2 form, SSI letter, SSDI, unemployment, workers' compensation, etc) ❑ Yes ❑ No

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

❑ I want Takeda Oncology Here2Assist to conduct an e-income verification which will include a soft credit check to determine household income.

❑ I understand that I am hereby providing "written instructions," under the Fair Credit Reporting Act (FCRA), authorizing Takeda Oncology Here2Assist and its vendors to obtain a consumer report or other information about me from (the vendor) for the purpose of determining my financial eligibility for the Takeda Oncology Here2Assist Patient Assistance Program. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process for Takeda Oncology Here2Assist.

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 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): _____

❑ Valid prescription attached (must be faxed with application)

STATEMENT OF MEDICAL NECESSITY

ICD-10 Code: _____

*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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Takeda Oncology Here2Assist®

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Takeda Oncology Patient Assistance Program

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 1 year 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.

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Takeda Oncology Patient Assistance Program

PATIENT ASSISTANCE APPLICATION PATIENT AUTHORIZATION

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, 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.

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:**_____

PRESCRIBER 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, I have exercised my independent medical judgment in writing this prescription for the patient above, and the prescription complies with all applicable local and state laws. 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 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.

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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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