



PATIENT ASSISTANCE PROGRAM

PO Box 66552
St. Louis, MO 63166-6552

FOR QUESTIONS, PLEASE CALL:

1.800.830.9159 PHONE

1.800.497.0928 FAX

WHO MAY BE ELIGIBLE

- You may qualify for the Takeda Patient Assistance Program if...
- You are a resident of the United States
 - You have no prescription coverage through private or government programs (*Medicare Part D eligible and enrolled applicants will be considered under certain circumstances*)
 - Your total income does not exceed:

2009 Federal Poverty Chart (300%)

# of Persons in Family Household	Annual Income
1	\$32,490
2	\$43,710
3	\$54,930
4	\$66,150
5	\$77,370

Please note that amounts may differ in Alaska and Hawaii, and may also change annually.

STEPS TO APPLY

- Complete all patient and doctor sections of the attached application
 - Patient must sign the application in Section 4
 - Doctor must sign the application in Section 3
- Attach a copy of the patient's most recent year federal tax return or financial documentation. Examples include:
 - IRS Form 1040, 1040EZ
 - IRS Form 4506T
 - Yearly Benefits Statement (SSA-1099)
 - Social Security Disability Statement
- Attach an original prescription
- If patient has applied to Medicaid within the past year and has been denied, attach a copy of the denial letter
- If patient is Medicare Part D eligible or enrolled, Section 5 or 6 must be completed
- Submit application and documentation by mail or fax listed above

TAKEDA PRESCRIPTION MEDICINES

For a complete list of medications available on the Takeda Patient Assistance Program:

- Call 1-800-830-9159 and select option 2
- Online at www.tpna.com *select-Responsibility select-Patient Assistance Program*

Medications available through the Takeda Patient Assistance Program are subject to change at any time.

Once your application is received, it will be reviewed and your eligibility for participation in the Takeda Patient Assistance Program will be evaluated. You and/or your doctor will be notified by mail about your eligibility status within 5-7 days after receipt of application.

If you have any questions or need further assistance, please call a Takeda Patient Assistance Program representative at 1-800-830-9159, Monday through Friday, 7:30 am to 5:00 pm CT.

Please print clearly in black or blue ink

SECTION 1 Patient Information

Patient First Name, Last Name	Date of Birth (mm/dd/yyyy) / /
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Address

City	State	Zip	Phone ()
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Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Female <input type="checkbox"/> Male	US Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
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Patient Social Security # Green Card or Visa # (if no SS #)	US Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No
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Medication will be shipped to patient address unless otherwise requested. Patient Doctor

Medicines: List any medicines that you are taking: _____ _____ _____	List any medicines that you are allergic to: _____ _____ _____
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SECTION 2 Insurance & Income

Do you have any form(s) of prescription drug insurance? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Employer furnished or private drug coverage | <input type="checkbox"/> State assistance program for medicines |
| <input type="checkbox"/> VA or military benefits | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> None |
| <input type="checkbox"/> Medicare Part D* | |

Have you applied for Medicaid in the past and been denied? Yes No

If yes, please attach a copy of the Medicaid denial letter.

**Section 5 or 6 on page 4 must be completed for all Medicare Part D enrolled or eligible applicants.*

Number of people in your household (yourself, your spouse, and dependents) _____

Total combined income for yourself, your spouse, and dependents
\$ _____ Monthly **or** \$ _____ Yearly

Do you have a copy of your federal income tax return from last year?

YES

Please send us a copy of last year's **Federal Income Tax Return(s)** for yourself, your spouse, and dependents. If your income has changed significantly, or if you no longer are employed, send a new income statement or proof of unemployment.

NO

If you did not file a federal income tax return last year, you **must** send us a copy of:

- IRS Form 4506T (W2 or 1099) **and**
- Social Security Income Yearly Benefits Statement **or**
- All income statements from jobs

If you do not have any of these documents, please call 1-800-830-9159.

SECTION 3 Doctor Information		
Doctor: First Name, Last Name		DEA or State License #
Address		
City	State	Zip
Phone ()	Fax ()	
My signature certifies that (1) this patient has demonstrated medical and financial need for assistance and has consented to share, upon request, his or her health and financial information with Takeda Pharmaceuticals America, Inc. ("Takeda") and its contractors to confirm eligibility and to administer participation in the program, and (2) this information is accurate and complete to the best of my knowledge. When the product is sent to my office on behalf of the patient, I understand that it must be used for that patient, 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.		
Signature of Doctor X		Date
SECTION 4 PATIENT HIPAA AUTHORIZATION & CERTIFICATION		
<p>I request and authorize my physician (named above) and my health insurance company (if any) to disclose to Takeda Pharmaceuticals America, Inc. ("Takeda") and its affiliated companies, or third party contractors assisting Takeda in connection with the Takeda Patient Assistance Program ("Program"), all personal information relating to my medical condition, treatment and insurance coverage needed to determine my eligibility and administer my participation in the Program.</p> <p>I may refuse to sign this authorization. If I refuse, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment, or affect my insurance enrollment or eligibility for insurance benefits. I may cancel this authorization at any time by mailing a letter of cancellation to Takeda at the address listed at the bottom of this application form. If I cancel this authorization, I will no longer be allowed to participate in the Program. Cancelling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed by Takeda, but will not affect disclosures made before that time.</p> <p>I understand that once my personal information is disclosed to Takeda or its contractors, federal privacy laws may no longer protect the information from further disclosure. However, my personal information will not be used or disclosed by Takeda or its contractors for any purpose other than to determine my eligibility and to administer my participation in the Program. This authorization expires at the end of my participation in the Program.</p> <p>I certify that the information on this form is accurate and complete to the best of my knowledge, and that no third party will be charged for the product made available under this program. I agree that Takeda and its contractors may also contact my health insurer to verify my insurance information.</p>		
Signature of Patient or Legal Guardian X		Date

Before you mail this application:

- Attach your prescription
- Attach a copy of last year's financial documentation
- Medicare Part D **enrolled and eligible** applicants **must** complete Section 5 or 6 on page 4
- Make sure you and your doctor sign the application

Mail completed application and documentation to:
 Takeda Pharmaceuticals America, Inc.
 PO Box 66552
 St. Louis, MO 63166-6552 **OR**
Fax to:
 1-800-497-0928 (from doctor's office)

FOR MEDICARE PART D ELIGIBLE AND/OR ENROLLED APPLICANTS ONLY

SECTION 5 Medicare Part D Prescription Drug Plan Contact Information

1. I understand that if approved for assistance, I will be able to receive the requested medication from the Takeda Patient Assistance Program (“Program”) for the remainder of the enrollment calendar year* for which my application was approved.
2. I agree that I will not seek the requested medication from my Medicare Part D plan for the remainder of the enrollment calendar year.*
3. I agree that I will not seek or accept reimbursement from my Medicare Part D Plan for any medication received from the Program.
4. I agree that I will 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.
5. I give consent for the Program to disclose my enrollment in the Program to my Medicare Part D plan.
6. I agree to notify the Program immediately, in writing, if my prescription drug coverage changes in any way.

**Enrollment calendar year is the calendar year for which this application is being submitted.*

Medicare Drug Plan Name:

Medicare Drug Plan Address:

City	State	Zip
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Signature of Patient X	Date
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SECTION 6 Affirmation of Non-Enrollment in Medicare Part D Plan

This section must be completed by any new applicant or re-enrollee who is eligible for Medicare Part D, but is not enrolled in a Medicare Part D plan OR does not qualify for Medicare and is 65 years or older.

1. I declare and affirm that I am not currently enrolled in a Medicare Part D Plan OR I am 65 years or older and do not qualify for Medicare.
2. I agree to notify the Program immediately, in writing, if my prescription drug coverage changes in any way.

Signature of Patient X	Date
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Medicare Part D **enrolled and eligible** applicants, this sheet **must** be included with your application.

Mail completed application and documentation to:
 Takeda Pharmaceuticals America, Inc.
 PO Box 66552
 St. Louis, MO 63166-6552 **OR**
Fax to:
 1-800-497-0928 (from doctor’s office)