Find help with the cost of medicine

Thank you for downloading this patient assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER - Send your completed application to address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Patient Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.

- **Free, Low Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low cost, and sliding scale medical and dental clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.

- **Coupons, Rebates & More** — You can use the NeedyMeds website to find nearly 2,000 cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.

- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. To date, our drug discount card has saved patients over $244,000,000. Check out the next page to learn more.

Feel free to call our toll-free helpline if you have any questions. You can reach us at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thanks for using NeedyMeds! Please let us know if we can do anything else to help you afford the costs of your healthcare.

Richard J. Sagall, MD
President, NeedyMeds

NeedyMeds.org
P.O. Box 219
Gloucester, MA 01931

Helpline: 1-800-503-6897
Email: info@needymeds.org

www.needymeds.org

Clip the card and save

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

You can also save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
PO Box 219
Gloucester, MA 01931

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

HEMATOLOGY SUPPORT CENTER ENROLLMENT FORM

Fax: 866-467-7740 Phone: 888-229-8379

Downloaded from NeedyMeds.org

INSTRUCTIONS FOR COMPLETION OF FORM

1. Patient Information | 2. Insurance Information | 3. Prescriber Information

- **Fill out these sections completely**
- **Attach an enlarged, legible copy of the patient's insurance card(s)**
- **Do not submit to Takeda any documentation of labs, clinical history, or other documents supporting the prior authorization process**

For specific product support services, please see additional information below when completing the form.

For Copay Assistance:

- **Patient Authorization to Share Personal Health Information and Hematology Support Center Enrollment** must be completed by the patient
- The patient signature is required to allow personal health information to be shared with Takeda to facilitate access for patient to receive product support services, if eligible
  - Benefits investigation to confirm eligibility
  - Copay support (when applicable) and information about third-party financial assistance programs, as necessary
- (Optional) **Consent for Future Information** can be indicated if patient is interested in receiving marketing and promotional communications

For Healthcare/Insurance Education:

- **Patient Authorization to Share Personal Health Information and Hematology Support Center Enrollment** must be completed by the patient
- The patient signature is required to allow personal health information to be shared with Takeda to facilitate access for patient to receive product support services, if eligible
- (Optional) **Consent for Future Information** can be indicated if patient is interested in receiving marketing and promotional communications

For Benefit Investigation:

- **Prescriber's Certification** must be completed by the physician

For Access/Appeals Support:

- **Prescriber's Certification** must be completed by the physician
- **Patient Authorization to Share Personal Health Information and Hematology Support Center Enrollment** must be completed by the patient
- The patient signature is required to allow personal health information to be shared with Takeda to facilitate access for patient to receive product support services, if eligible
- (Optional) **Consent for Future Information** can be indicated if patient is interested in receiving marketing and promotional communications

Fax completed forms to [866-467-7740]

WHAT HAPPENS NEXT

- **Once the completed form has been submitted to the Hematology Support Center, a dedicated Case Manager will be assigned to the eligible patient and/or healthcare provider office**
- **For co-pay assistance, the Case Manager will contact the patient directly to inform him or her of the services available and to begin the process**
- **For Healthcare Educator or Patient Access Manager immediate requests the appropriate dedicated service member will be reaching out to you**
- **For benefit investigation or denials/appeals support, the Case Manager will contact the healthcare provider office**
- **If applicable, the Case Manager will work with the insurance company to determine insurance benefits**

HEMATOLOGY SUPPORT CENTER ENROLLMENT FORM

Fax: 866-467-7740 Phone: 888-229-8379

Downloaded from NeedyMeds.org

1. Patient Information

Current Takeda Product: ______

Product Provider Name (for example, specialty pharmacy, treatment center): ______

Patient Name (first, last): ______ Gender: ☐ M ☐ F

Date of Birth (MM/DD/YYYY): ______ Age (years): ______

Street Address: ______ City: ______ State: ______ ZIP: ______

Primary Phone: ______ Email: ______

Caregiver Name: (first, last): ______ Phone: ______ Email: ______

☐ Please check the box if you are the patient's Legal Representative. Relationship to Patient: ______

Primary Language: ______

2. Insurance Information—Please include a copy of the front and back of the patient's insurance card(s)

☐ Check here if the patient does not have insurance

Primary Insurance: ______ Insurance Phone #: ______

Subscriber: ______ Policy ID #: ______ Group #: ______

Secondary Insurance: ______ Insurance Phone #: ______

Subscriber: ______ Policy ID #: ______ Group #: ______

Pharmacy Plan Name: ______ Pharmacy Plan Phone: ______

Policy ID #: ______ Policy Group #: ______ Rx BIN #: ______ Rx PCN #: ______

Medicare Part D Plan?: ☐ Yes ☐ No Insurance Phone #: ______

Subscriber: ______ Policy ID #: ______ Group #: ______

3. Prescriber Information

Prescriber Name (first, last): ______ Office Contact: ______

Tax ID #: ______ NPI #: ______ PTAN: ______

Facility Name: ______

Facility Address: ______ City: ______ State: ______ ZIP: ______

Phone: ______ Fax: ______ Email: ______

4. Prescriber's Certification

By signing below, I certify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge. I certify that I have received the necessary written authorization from the patient to release the medical and/or patient information referenced on this form relating to the above-referenced patient to Takeda and its affiliates, agents, representatives, and contracted third parties (collectively "Takeda") for the purposes of seeking reimbursement support, verifying insurance coverage and/or the evaluation of the patients eligibility for alternate sources of funding, contacting the patient for the purpose of enrollment in the Hematology Support Center or similar Takeda product support services, including materials fulfillment, and product fulfillment via specialty pharmacies. I understand that Takeda may need additional information, and I agree to provide it as needed for such purposes.

Prescriber Signature: ______ **Date:** ______

Downloaded from NeedyMeds.org

Hematology Support Center

Patient Name (first, last): ______________________ Date of Birth (MM/DD/YYYY): ______________

5. Patient Authorization to Share Personal Health Information and Hematology Support Center Enrollment

I authorize any health plan, physician, healthcare professional, hospital, clinic, pharmacy provider, or other healthcare provider (collectively, "Providers") to disclose my protected health information, including personal information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Information"), to Takeda Pharmaceutical Company Limited, its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "Takeda") in connection with the Company's provision of products, supplies, or services. I understand the Company will provide this Information to a specialty pharmacy to fulfill the prescription. This Information may also be used for internal uses by the Company, including data analysis.

Further, I am electing to enroll in the Hematology Support Center Product Support Services. I understand the Company may use this Information for the provision of Hematology Support Center Product Support Services such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, alternate funding sources, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance.

Additionally, if I check the box below regarding marketing communications, I authorize the Company to use and disclose my Information to send marketing materials to me (as described below).

I understand that employees of the Company only see my Personal Health Information in connection with administering the Hematology Support Center Product Support Services, or in connection with other activities referenced herein, or as otherwise required or allowed under the law. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, my Personal 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 at any time by sending written notice of revocation to Hematology Support Center, 300 Shire Way, Lexington, MA 02421. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from today's date, 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 Hematology Support Center Product Support Services products, supplies, or services.

Signature of Patient (required): ______________________ Date: ____________

Legal Representative Name and Relationship to Patient (if applicable): ______________________

Legal Representative Signature (if applicable): ______________________ Date: ____________

Consent for Future Information

☐ By checking this box, I authorize the use of my Information for Takeda marketing activities and consent to receiving marketing and promotional communications from Takeda. I hereby 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 to Takeda. I understand that this consent will be in effect until such time as I cancel such authorization.

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