

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

REMEMBER — Send your completed application to the 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 "**Healthcare 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, dental, mental health and substance abuse 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 2,600+ 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.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, \$4 generic drug programs, and more.

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. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over \$300,000,000. Check out the following page to learn more.

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

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



Rich Sagall, MD
President, NeedyMeds

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.



- 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.

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.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

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
50 Whittemore St.
Gloucester, MA 01930

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.



Takeda Help At Hand
PO Box 5727, Louisville, KY 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 must:

- 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 <https://aspe.hhs.gov/poverty-guidelines>)
- Not have access to alternate sources of coverage or funding
- Have recently lost your job and are experiencing financial hardship

CHECKLIST FOR SUBMITTING APPLICATION

Complete Sections 1, 2, 5, and 6, including two patient signatures

Attach patient current proof of income as outlined in Section 2

Have healthcare provider complete both sections 3 and 4, provide a signature at the bottom of section 4, and fax or mail the completed application and all documentation to the address above.

Application and attachments must be faxed or mailed to Help at Hand by the healthcare provider.

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



Application type: Initial Renewal

SECTION 1: PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Email Address: _____

By checking yes below, I authorize Takeda HAH Patient Assistance Program to send text messages to my cell phone to convey important information related to my application status or potential shipments. I understand that standard text messaging rates will apply to any messages received from Takeda HAH Patient Assistance Program. I also understand that I or Takeda HAH Patient Assistance Program may revoke this permission in writing at anytime. I further agree that in the event that my cellphone phone number changes I will inform the program. I authorize receiving program communication via text.

Yes No

DOB (MM/DD/YYYY): _____ Gender: Male Female U.S. Resident: Yes No

Medicare Number (MBI) _____ (This number is 11 characters in length and made up only of numbers and upper case letters.)

SECTION 2: INSURANCE AND INCOME

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

None VA/Military benefits Health exchange plan Medicare
Employer supplied/private coverage Medicaid (if box is checked please enter your MBI number in section 1)

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: **Required**

- 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.

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



Patient First Name:

Patient Last Name:

DOB:

SECTION 3: PRESCRIBER INFORMATION

First Name: _____ Last Name: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ ZIP Code: _____
 State License Number: _____ NPI #: _____

SECTION 4: PRESCRIPTION INFORMATION

(NJ and NY physicians please attach appropriate prescription)

Allergies: _____ No Known Allergies
 Health Conditions: _____ None
 Current Medications: _____ None

Product <i>(Please select and complete ship product to below)</i>	Strength	Directions	Quantity	Refills <i>(please select)</i>
AMITIZA® (lubiprostone) Capsules	_____ mcg	_____	90-days	1 2 3
CARBATROL® (carbamazepine) Extended-Release Capsules	_____ mg	_____	90-days	1 2 3
COLCRYS® (colchicine, USP) Tablets	0.6 mg	_____	90-days	1 2 3
DEXILANT® (dexlansoprazole) Delayed-Release Capsules	_____ mg	_____	90-days	1 2 3
FOSRENOL® (lanthanum carbonate) Chewable Tablets	_____ mg	_____	90-days	1 2 3
FOSRENOL® (lanthanum carbonate) Oral Powder	_____ mg	_____	90-days	1 2 3
INTUNIV® (guanfacine) Extended-Release Tablets	_____ mg	_____	90-days	1 2 3
KAZANO® (alogliptin and metformin HCl) Tablets	_____ mg	_____	90-days	1 2 3
LIALDA® (mesalamine) Delayed-Release Tablets	1.2 gm	_____	90-days	1 2 3
MOTEGRITY® (prucalopride) Tablets	_____ mg	_____	90-days	1 2 3
MYDAYIS® (mixed salts of a single-entity amphetamine product) Extended-Release Capsules CII	<i>Pharmacy pick up only; physician must provide a prescription. Maximum daily dose for 13-17 yrs: 25mg; Maximum daily dose for adults: 50mg</i>		DEA#:	
NESINA® (alogliptin) Tablets	_____ mg	_____	90-days	1 2 3
OSENI® (alogliptin and pioglitazone) Tablets	_____ mg	_____	90-days	1 2 3
PENTASA® (mesalamine) Extended-Release Capsules	_____ mg	_____	90-days	1 2 3
PREVACID SOLUTAB® (lansoprazole) Delayed-Release Orally Disintegrating Tablets	_____ mg	_____	90-days	1 2 3
ROZEREM® (ramelteon) Tablets	8 mg	_____	90-days	1 2 3
TRINTELLIX® (vortioxetine) Tablets	_____ mg	_____	90-days	1 2 3
VYVANSE® (lisdexamfetamine dimesylate) Capsules CII	<i>Pharmacy pick up only; physician must provide a prescription. Maximum daily dose: 70 mg</i>		DEA#:	
VYVANSE® (lisdexamfetamine dimesylate) Chewable Tablets CII	<i>Pharmacy pick up only; physician must provide a prescription. Maximum daily dose: 70 mg</i>		DEA#:	

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

TRINTELLIX, AMITIZA, PREVACID SOLUTAB, COLCRYS, DEXILANT, NESINA, OSENI, KAZANO, ROZEREM, CARBATROL, MOTEGRITY, INTUNIV, VYVANSE, MYDAYIS, FOSRENOL, LIALDA, PENTASA, TAKEDA and the TAKEDA logo are trademarks or registered trademarks of Takeda Pharmaceutical Company Limited or its subsidiaries and affiliated companies.

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.

I certify that my signature encompasses any other doctor in my practice/organization. I certify that there will be no charge back cost to the patient above.

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 to 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:



Patient First Name: _____

Patient Last Name: _____

DOB: _____

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;
6. I want Takeda Help at Hand Patient Assistance Program ("PAP") to conduct 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 the PAP and its vendors to run a soft credit check or other information about me from (the vendor) for the purpose of determining my financial eligibility for the PAP. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process for the PAP. I also understand that I may need to provide additional documentation and that additional eligibility requirements apply for the PAP.

Patient Signature/Legal Representative (*indicate relationship*)

The parties agree that this Amendment may be executed and delivered by electronic signatures and that the signatures appearing on this Amendment are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

SIGN 	X _____	Date: _____
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If signature is of legal representative:

Legal Representative Name: _____ Relationship to Patient: _____

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.



Patient First Name:

Patient Last Name:

DOB:

SECTION 6: PATIENT AUTHORIZATION

PLEASE READ THE FOLLOWING 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 cancellations 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:** _____

If signature is of legal representative:

Legal Representative Name: _____ Relationship to Patient: _____

What happens next? You and/or your healthcare provider will receive an answer from Takeda Help At Hand 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 U.S.A., Inc. programs, can be discontinued or changed at any time without notice at the discretion of Takeda Pharmaceuticals America, Inc.

Takeda Help At Hand
PO Box 5727, Louisville, KY 40255-0727
Phone: 1-800-830-9159 Fax: 1-800-497-0928