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

NeedyMeds
NeedyMeds.org

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.

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 Patient Support
For Livtencity
Your Source for Education and Access

LIVTENCITY™ (maribavir)

PATIENT START FORM

TAKEDA PATIENT SUPPORT: YOUR SOURCE FOR EDUCATION AND ACCESS

Takeda Patient Support is here to help eligible patients get their LIVTENCITY as prescribed. We can help with product access, educational resources, and financial assistance options.

Takeda Patient Support will:

1. Provide support during the benefits verification process
2. Triage and coordinate with the specialty pharmacy to fill the prescription as soon as possible
3. Work with the specialty pharmacy to identify financial assistance options for eligible patients, if needed

Your patients do not need to be present when completing the Start Form.

Please direct your patients to text YES to 1-844-972-4268 after you have submitted the Start Form.

2 WAYS TO ENROLL IN TAKEDA PATIENT SUPPORT:

1. **Fill out** the Start Form online at **tps-hcp.iassist.com**
2. **Fax** the Start Form to **1-855-268-1826**

Questions?

Call Takeda Patient Support at 1-855-268-1825 Monday-Friday, 8 AM to 8 PM ET.

Reset Form

Takeda Patient Support For Livtencity
Your Source for Education and Access

LIVTENCITY™ (maribavir) PATIENT START FORM

Enroll through one of the following contact methods: tps-hcp.iassist.com FAX: 1-855-268-1826

Questions? Call Takeda Patient Support at 1-855-268-1825 Monday-Friday, 8 AM to 8 PM ET

STEPS TO ENROLL YOUR PATIENT:

SECTIONS 1-3: Please provide your patient's information.

SECTIONS 4 AND 5: Please provide prescriber and prescription information.

PLEASE CHECK THE BOX THAT APPLIES:

☐ Medication readiness/registration

☐ Immediate dispense required

If requesting immediate access for your patient, please complete the Quick Start field in section 5.

1 PATIENT INFORMATION

LEGAL NAME (FIRST, MIDDLE, LAST)		GENDER* ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YYYY)
PRIMARY PHONE ☐ HOME ☐ WORK ☐ CELL		SECONDARY PHONE ☐ HOME ☐ WORK ☐ CELL	
SHIPPING ADDRESS (NO PO BOX)			
CITY	STATE / ZIP	EMAIL ADDRESS	
CAREGIVER LEGAL NAME		CAREGIVER PRIMARY PHONE ☐ HOME ☐ WORK ☐ CELL	
RELATIONSHIP TO PATIENT	PATIENT PREFERRED LANGUAGE	PREFERRED CONTACT METHOD ☐ PHONE ☐ TEXT ☐ EMAIL	

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

2 PATIENT INSURANCE INFORMATION (Please attach copies of both sides of patient's insurance card[s])

PRIMARY INSURANCE	☐ PATIENT DOES NOT HAVE INSURANCE	INSURANCE PHONE	
POLICY ID #	GROUP #		
POLICY HOLDER NAME (FIRST, LAST)	RELATIONSHIP TO PATIENT	POLICY HOLDER DOB (MM/DD/YYYY)	
SECONDARY INSURANCE		INSURANCE PHONE	
POLICY ID #	GROUP #		
POLICY HOLDER NAME (FIRST, LAST)	RELATIONSHIP TO PATIENT	POLICY HOLDER DOB (MM/DD/YYYY)	
PHARMACY PLAN NAME	PHARMACY PLAN PHONE		
Rx # ID / Rx GROUP #	Rx PCN #	Rx BIN #	

3 PATIENT INCOME INFORMATION†

LAST FOUR DIGITS OF SS # ____ ____ ____ ____	# OF PEOPLE IN HOUSEHOLD	TOTAL ANNUAL HOUSEHOLD INCOME (BEFORE TAXES)

†The program will leverage soft credit check tools to determine the patient's eligibility for Patient Assistance Program. Additional documentation may be required and additional eligibility requirements apply.

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PATIENT INFORMATION

LEGAL NAME (FIRST, MIDDLE, LAST)	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YYYY)

4 PRESCRIBER INFORMATION

PRESCRIBER NAME	PRACTICE NAME	HOSPITAL AFFILIATION	NPI

PRACTICE ADDRESS	CITY	STATE	ZIP

TRANSPLANT FACILITY NAME	TRANSPLANT FACILITY PHONE

NAME OF TRANSPLANT CENTER COORDINATOR	TRANSPLANT CENTER COORDINATOR TITLE	PRIOR AUTHORIZATION SUBMITTED? ☐ YES ☐ NO

CONTACT PHONE ☐ CELL ☐ OFFICE	CONTACT FAX	CONTACT EMAIL

5 PRESCRIPTION INFORMATION (TO SUBMIT ELECTRONICALLY, VISIT TPS-HCP.IASSIST.COM)

STANDARD DOSE

Dispense: LIVTENCITY™ (maribavir) 200 mg ☐ **SIG:** 2 tablets PO BID

ADJUSTED DOSING: PER LIVTENCITY PRESCRIBING INFORMATION, ADJUSTED DOSING IS RECOMMENDED FOR THE FOLLOWING CONCOMITANT MEDICATIONS:

Carbamazepine
Dispense: LIVTENCITY™ (maribavir) 200 mg ☐ **SIG:** 4 tablets PO BID

Phenobarbital
Dispense: LIVTENCITY™ (maribavir) 200 mg ☐ **SIG:** 6 tablets PO BID

Phenytoin
Dispense: LIVTENCITY™ (maribavir) 200 mg ☐ **SIG:** 6 tablets PO BID

Qty: _____ **Refills:** _____

QUICK START PROGRAM

Dispense: LIVTENCITY™ (maribavir) 200 mg ☐ **SIG:** 2 tablets PO BID
Qty: 28 **Refills:** 1

ADJUSTED DOSING: PER LIVTENCITY PRESCRIBING INFORMATION, ADJUSTED DOSING IS RECOMMENDED FOR THE FOLLOWING CONCOMITANT MEDICATIONS:

Carbamazepine
Dispense: LIVTENCITY™ (maribavir) 200 mg ☐ **SIG:** 4 tablets PO BID
Qty: 56 **Refills:** 1

Phenobarbital
Dispense: LIVTENCITY™ (maribavir) 200 mg ☐ **SIG:** 6 tablets PO BID
Qty: 84 **Refills:** 1

Phenytoin
Dispense: LIVTENCITY™ (maribavir) 200 mg ☐ **SIG:** 6 tablets PO BID
Qty: 84 **Refills:** 1

☐ **Patient diagnosis: FDA-approved indication for LIVTENCITY**

DX CODE: _____ TYPE OF TRANSPLANT: _____ ☐ Medication list attached

CURRENT TRANSPLANT SPECIALTY PHARMACY (THIS PRODUCT IS DISTRIBUTED THROUGH A LIMITED SPECIALTY PHARMACY NETWORK)	PHARMACY PHONE	PHARMACY FAX

PHARMACY ADDRESS

SIGNATURE REQUIRED	PRESCRIBER SIGNATURE	DATE (MM/DD/YYYY)

- By signing this form, I certify that therapy with LIVTENCITY is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current LIVTENCITY Prescribing Information and will be supervising Patient's treatment. I have received from Patient, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state law regulations, referenced medical and/or other patient information relating to LIVTENCITY therapy to Takeda Pharmaceuticals U.S.A., Inc., including its agents or contractors (the "Company"), for the purpose of seeking information related to coverage and/or assisting in initiating or continuing LIVTENCITY therapy. I authorize Takeda Patient Support to transmit this prescription to the appropriate pharmacy designated by me, Patient, or Patient's plan. I agree that product provided through the Program shall only be used for Patient, and must not be resold, offered for sale or trade, or returned for credit. I understand that I am under no obligation to prescribe LIVTENCITY or any other product manufactured by the Company, and I certify I have received nothing of value from the Company or its agents or representatives for prescribing a Company product.
- I certify that I have reviewed the additional terms available at https://ebvterms.com/terms, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regards to this certification.

SIGNATURE REQUIRED	PRESCRIBER SIGNATURE	DATE (MM/DD/YYYY)

PATIENT AUTHORIZATION FOR LIVTENCITY™ (maribavir)

Enroll through one of the following contact methods: tps-hcp.iassist.com FAX: 1-855-268-1826

Questions? Call Takeda Patient Support at 1-855-268-1825 Monday-Friday, 8 AM to 8 PM ET

PATIENT INFORMATION		
LEGAL NAME (FIRST, MIDDLE, LAST)	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YYYY)

PATIENT HIPAA AUTHORIZATION

By signing the Patient Authorization section below, 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 and any prescription ("Protected Health Information"), to Takeda Pharmaceuticals U.S.A., Inc. and its present or future affiliates and their representatives, agents, and contractors, including the affiliates and service providers that work on Takeda's behalf in connection with the Takeda Patient Support Program (collectively the "Companies"). The Companies will use my Protected Health Information for the purpose of facilitating the provision of the Takeda Patient Support Program products, supplies, or services as selected by me or my physician and may include (but not be limited to) verification of insurance benefits and drug coverage, prior authorization education, financial assistance with co-pays, patient assistance programs, alternate funding resources, and other related programs. Specifically, I authorize the Companies to 1) receive, use, and disclose my Protected Health Information in order to enroll me in Takeda Patient Support and contact me, and/or the person legally authorized to sign on my behalf, about Takeda Patient Support; 2) provide me, and/or the person legally authorized to sign on my behalf, with educational materials, information, and services related to Takeda Patient Support; 3) verify, investigate, and provide information about my coverage for LIVTENCITY, including but not limited to communicating with my insurer, specialty pharmacies, and others involved in processing my pharmacy claims to verify my coverage; 4) coordinate prescription fulfillment; and 5) use my information to conduct internal analyses.

I understand that employees of the Companies only use my Protected Health Information for the purposes described herein, to administer the Takeda Patient Support Program or as otherwise required or allowed under the law, unless information that specifically identifies me is removed. Further, I understand that my healthcare provider may receive financial remuneration from Takeda Pharmaceuticals U.S.A., Inc. for marketing services. I understand that once my Protected Health Information is disclosed under this Authorization, it 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 Notice available at www.takeda.com/privacy-notice/. I understand that such cancellation 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 and provided on the first page of this enrollment form, 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 Takeda Patient Support Program products, supplies, or services.

SIGNATURE REQUIRED

PATIENT AUTHORIZATION (I have read, understand, and agree to the release of my protected health information as described above)	DATE (MM/DD/YYYY)
PATIENT SIGNATURE	

LIVTENCITY™ (maribavir) PATIENT START FORM

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Questions? Call Takeda Patient Support at 1-855-268-1825 Monday-Friday, 8 AM to 8 PM ET

PATIENT INFORMATION

LEGAL NAME (FIRST, MIDDLE, LAST)	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YYYY)

TAKEDA PATIENT SUPPORT ENROLLMENT

By signing below, I am electing to enroll in Takeda Patient Support Services ("Services") and direct all disclosures of my Information in connection with such Services (which may include, but are not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, 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).

SIGNATURE REQUIRED

PATIENT SUPPORT ENROLLMENT (I have read, understand, and agree to the use of my personal information for the purposes described above)	DATE (MM/DD/YYYY)
PATIENT SIGNATURE	

PAP FINANCIAL INFORMATION (For PAP eligibility determination only):

INITIALS REQUIRED ☐ I want LIVTENCITY 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.

- OR -

INITIALS REQUIRED ☐ Most recent income documentation attached (IRS form 1040, 1099, W-2 Form, etc).

I DECLARE AND AFFIRM THAT:

1. The information provided by me on this enrollment form is true and accurate;
2. I give consent to the PAP to disclose my enrollment in the PAP as needed to comply with legal and regulatory obligations;
3. I agree to notify the PAP immediately, in writing, if my prescription drug coverage changes in any way;
4. I will not seek or accept reimbursement from any health or prescription coverage plan, including a Medicare plan, for medication received from the PAP;
5. I understand that if I am eligible or enrolled in a Medicare plan, I will
- **a)** receive the requested medication from the PAP 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 PAP because I understand that medication received from the PAP 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 PAP;

6. I understand the product will be shipped to the home site on my behalf.

TEXT MESSAGING AGREEMENT TERMS & CONDITIONS

INITIALS REQUIRED ☐ By agreeing to these Takeda Patient Support (the "Program") text message terms and conditions, you agree to receive text messages on your mobile device subject to the Terms & Conditions described below. You also consent to receive autodialed and/or pre-recorded calls and/or text messages from or on behalf of the Program at the telephone number provided above. You understand that this consent is not a condition of purchase or use of the Program or of any Takeda product or service. Participants will receive an average of 5 text messages each month while enrolled in the Program. Such messages may be nonmarketing messages related to the Patient Support 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 in to 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 1-855-268-1825. 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, and 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 cellular providers.

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 us 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 to 1-844-972-4268. For questions about this Program, text HELP or contact the customer support center at 1-855-268-1825.

Consent for Marketing Communications

INITIALS REQUIRED ☐ By initialing 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 above. I understand that this consent will be in effect until I cancel such authorization.

US-MAR-0179v1.0 11/21