ADZYNMA
ADAMTS13, recombinant-krhn

Fax pages 2-6 to **866-467-7740** | Phone: **888-229-8379**

Instructions for Completion of Form

- Complete sections 1-8 and **FAX PAGES 2-6 to 866-467-7740** and attach a copy of the patient's insurance card (front and back)
- Do not submit to Takeda any documentation of labs, clinical history, or other documents supporting the prior authorization process

1 Patient Information

2 Insurance Information

3 Prescriber Information

4 ADZYNMA Prescription Information and Prescribing Physician Signature

- Please indicate the number of refills
- This is a prescription; a physician's signature and date are required

Rx: ADZYNMA [ADAMTS13, recombinant-krhn] (Enzyme Replacement Therapy for Prophylaxis)

Patient Name (First Name and Last Name): _____

Administer 40 IU/kg body weight of ADZYNMA once every other week or once weekly based on prior prophylactic dosing regimen or clinical response.

DOB (MM/DD/YYYY): _____

☐ **Diagnosis (ICD-10): M31.19 / D69.42[1]**

[1]Secondary code; Patients must first be coded as having a congenital or hereditary disorder before the secondary code can be applied. Payers may deny claims if the primary code is not found.

☐ **NKDA (No Known Drug Allergies)**

Patient Body Weight (kg): _____ **X** **40 (IU):** _____ **Total Dose (IU):** _____ **-every-** **Week(s):** _____

*Rx Product	*QTY	*No. of Refills
☐ ADZYNMA 500 nominal IU vials		
☐ ADZYNMA 1500 nominal IU vials		

***Preferred infusion site:** ☐ **Infusion suite** ☐ **Hospital Outpatient** ☐ **Prescriber office** **If different please specify:** _____
☐ **Triage to Specialty Pharmacy (when needed)**

Prescriber Attestation Statement:
By signing this form, I certify that therapy with ADZYNMA is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current ADZYNMA 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 ADZYNMA 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 ADZYNMA 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 or submitted for reimbursement to any third-party payer, including Medicare or Medicaid, either directly or indirectly. I understand that I am under no obligation to prescribe ADZYNMA 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.

Prescriber Signature: _____ **Date:** _____

The prescriber is required to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in a delay.

5 Site of Care Information

6 Patient HIPAA Authorization

The patient signature is required to allow personal health information to be shared by third parties to Takeda to facilitate access to ADZYNMA (insurance benefits, transfer RX to specialty pharmacy provider, etc).

7 Takeda Patient Support Enrollment

8 Text Messaging Agreement Terms & Conditions

PATIENT SUPPORT ENROLLMENT FORM

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

ADZYNMA
ADAMTS13, recombinant-krhn

1. Patient Information

*Patient Name (first, middle, last): _____ *Gender†: ☐ M ☐ F

†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.

*Date of Birth (MM/DD/YYYY): _____ Age (Years): _____

*Street Address: _____

*City: _____ *State: _____ *ZIP: _____ Email: _____

*Primary Phone: _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

*Patient Preferred Language: _____ *Patient Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

Legal Representative Name (if applicable): _____

Legal Representative Primary Phone: _____ ☐ Home ☐ Work ☐ Cell

Legal Representative Email: _____

Relationship to Patient: _____

2. Insurance Information

Please attach copies of both sides of patient's medical and prescription insurance cards.

☐ Check here if the patient doesn't have insurance

*Primary Insurance: _____ *Insurance Phone #: _____

*Subscriber (First, Last): _____ *Policy ID #: _____ *Group #: _____

*Pharmacy Plan Name: _____ *Pharmacy Plan Phone #: _____

*Rx ID #: _____ *Rx Group #: _____ *Rx BIN #: _____ *Rx PCN #: _____

Medicare Part D Plan: ☐ Yes ☐ No Insurance Phone #: _____

Subscriber (First, Last): _____ Policy ID #: _____ Group #: _____

Secondary Insurance: _____ Insurance Phone #: _____

Subscriber (First, Last): _____ Policy ID#: _____ Group #: _____

3. Prescriber Information

*Prescriber Name (First, Last): _____

Tax ID #: _____ *NPI #: _____ PTAN: _____

*Facility Name: _____

*Facility Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone: _____ *Fax: _____ Email: _____

*Required Fields *LEGAL NAME (first, middle, last) _____ *Date of Birth (MM/DD/YYYY) _____

4. ADZYNMA Prescription Information and Prescribing Physician Signature

Rx: ADZYNMA [ADAMTS13, recombinant-krhn] (Enzyme Replacement Therapy for Prophylaxis)

Patient Name (First Name and Last Name): _____

DOB (MM/DD/YYYY): _____

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Prescriber Attestation Statement:
By signing this form, I certify that therapy with ADZYNMA is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current ADZYNMA 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 ADZYNMA 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 ADZYNMA 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 or submitted for reimbursement to any third-party payer, including Medicare or Medicaid, either directly or indirectly. I understand that I am under no obligation to prescribe ADZYNMA 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.

Prescriber Signature: _____ **Date:** _____

5. Site of Care Information (required if different from prescriber, if applicable)

*Practice/Facility Name: _____

*Practice/Facility Address: _____

*City: _____ *State: _____ *ZIP: _____

Treating Physician (if applicable): _____

Tax ID #: _____ *NPI #: _____

*Preferred Contact Name (first, last): _____

*Phone: _____ *Fax: _____ *Email: _____

*Required Fields *LEGAL NAME (first, middle, last) _____ *Date of Birth (MM/DD/YYYY) _____

6. 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 my prescribed Takeda product, 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 physician, health insurance, and pharmacy providers may receive financial remuneration from the Companies for providing Protected Health Information, which may be used for marketing purposes. 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 can also revoke my Authorization by emailing PrivacyOffice@takeda.com or by calling 1-888-229-8379. 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 below, 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.

Patient Authorization: (I have read, understand, and agree to the release of my protected health information as described above)

*Signature of Patient: _____ *Date (MM/DD/YYYY): _____

*Legal Representative Name: _____ *Relationship to Patient: _____

*Legal Representative Signature: _____ *Date (MM/DD/YYYY): _____

I hereby attest that I am the legal representative of the patient and have the necessary legal authority to act on their behalf. I understand that providing false information may result in the termination of enrollment and potential legal consequences.

*Required Fields *LEGAL NAME (first, middle, last) _____ *Date of Birth (MM/DD/YYYY) _____

7. 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, disease state/product education, 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).

Takeda Patient Support Enrollment: (I have read, understand, and agree to the release of my protected health information as described above)

*Signature of Patient: _____ *Date (MM/DD/YYYY): _____

*Legal Representative Name: _____ *Relationship to Patient: _____

*Legal Representative Signature: _____ *Date (MM/DD/YYYY): _____

I hereby attest that I am the legal representative of the patient and have the necessary legal authority to act on their behalf. I understand that providing false information may result in the termination of enrollment and potential legal consequences.

OPTIONAL:

☐ **Consent for Marketing Information** By checking the box, I authorize the use of my Information for Takeda marketing activities and consent to receiving marketing and promotional communications from Takeda. Further, I understand that my physician, health insurance, and pharmacy providers may receive financial remuneration from the Companies for providing Protected Health Information, which may be used for marketing purposes. 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.

*Required Fields *LEGAL NAME (first, middle, last) _____ *Date of Birth (MM/DD/YYYY) _____

8. Text Messaging Agreement Terms & Conditions

By agreeing to these 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 in section 1. 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 1-888-229-8379. 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. To unsubscribe, or for questions about this Program, contact the customer support center at 1-888-229-8379.

Text Communication Enrollment: (I have read, understand, and agree to opt in for text communications as described above)

*Signature of Patient: _____ *Date (MM/DD/YYYY): _____

*Legal Representative Name: _____ *Relationship to Patient: _____

*Legal Representative Signature: _____ *Date (MM/DD/YYYY): _____

I hereby attest that I am the legal representative of the patient and have the necessary legal authority to act on their behalf. I understand that providing false information may result in the termination of enrollment and potential legal consequences.

Takeda

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