TAKEDA PATIENT SUPPORT ENROLLMENT FORM

Phone: 1-888-229-8379 **Fax:** 1-866-467-7740

Takeda Patient Support
Your Source for Education and Access

Takeda Patient Support is a program that can help eligible patients prescribed a Takeda Hematology product with education and resources to help access their therapy and support them through their treatment journey.

1. Please verify your Takeda Hematology product.*

- ☐ ADYNOVATE® [Antihemophilic Factor (Recombinant), PEGylated]
- ☐ ADVATE® [Antihemophilic Factor (Recombinant)]
- ☐ FEIBA® (anti-inhibitor coagulant complex)
- ☐ RIXUBIS® [Coagulation Factor IX (Recombinant)]

2. Patient Information

First Name* _____ Last Name* _____

Patient Preferred Language* _____ Date of Birth* (MM/DD/YYYY) _____ 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.

Address* _____ City* _____ State* _____ ZIP* _____

Email* _____ Primary Phone* _____ Phone Type* _____

3. Does this patient have a Legal Representative?

Yes ☐ No ☐ *If yes, the following information is required.*

Legal Representative First Name _____

Legal Representative Last Name _____ Relationship to Patient _____

Legal Representative Email _____ Legal Representative Phone _____

US-XMP-2807v3.0 08/26

TAKEDA PATIENT SUPPORT ENROLLMENT FORM

Phone: 1-888-229-8379 **Fax:** 1-866-467-7740

Takeda Patient Support
Your Source for Education and Access

Required Fields LEGAL NAME (first, middle, last) _____ Patient DOB (MM/DD/YYYY) _____

4. Insurance Information

☐ Please check this box if the patient does not have insurance.

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

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#

5. Prescriber Information

Prescriber First Name* Prescriber Last Name*

Tax ID# NPI#* PTAN

Facility Name* Office Contact*

Facility Tax ID* Facility NPI*

Facility Address* City* State* ZIP*

Email Phone* Fax*

6. Prescriber's Certification

By signing this form, 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 the prescribed Takeda product is medically necessary for the patient identified in this application ("Patient"). I have reviewed the associated 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 the requested medication 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 therapy. I agree that product provided through the Program shall only be used for Patient, and must not be resold, offered for sale or trade, returned for credit, either directly or indirectly. I understand that I am under no obligation to prescribe the requested medication 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's Signature* Date (MM/DD/YYYY)*

Required Fields LEGAL NAME (first, middle, last) _____ Patient DOB (MM/DD/YYYY) _____

7. Acknowledge

Please review the following and acknowledge to proceed.

Patient HIPAA Authorization

By signing the Patient Authorization section of this form, 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., Inc. and its present or future affiliates, including the affiliates and service providers that work on Takeda's behalf in connection with the Takeda Patient Support Program (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 support, financial assistance with co-pays, patient assistance programs, 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 the Takeda Patient Support Program and contact me, and/or the person legally authorized to sign on my behalf, about the Takeda Patient Support Program; 2) provide me, and/or the person legally authorized to sign on my behalf, with educational materials, information, and services related to the Takeda Patient Support Program; 3) verify, investigate, and provide information about my coverage, 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 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 revoke this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Notice available at http://www.takeda.com/privacy-notice/ or I may revoke this Authorization at any time by sending written notice of revocation to the Takeda Patient Support Program, PO Box 2355, Morristown, NJ 07962. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire at the earliest of what is required by state law, and never in any case longer than 5 years. I also understand that if I do not sign this Authorization, I will not be able to receive the 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)* _____

Required Fields LEGAL NAME (first, middle, last) _____ Patient DOB (MM/DD/YYYY) _____

8. Takeda Patient Support Services Enrollment

By signing below, I am electing to enroll in Takeda Patient Support for Hematology 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).

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)* _____

9. Marketing Communications OPTIONAL

☐ 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. 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.

TAKEDA PATIENT SUPPORT ENROLLMENT FORM

Phone: 1-888-229-8379 **Fax:** 1-866-467-7740

Takeda Patient Support
Your Source for Education and Access

Required Fields LEGAL NAME (first, middle, last) _____ Patient DOB (MM/DD/YYYY) _____

10. Text Messaging Agreement Terms & Conditions OPTIONAL

By agreeing to these Takeda Patient Support Program (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. You can unsubscribe from receiving text messages by texting STOP. You will remain enrolled in Takeda Patient Support. For questions about this Program, text HELP or contact the customer support center at 888-229-8379.

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 into 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 [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, as well as 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 U.S. carriers, including Verizon Wireless, Sprint, Nextel, Boost Mobile, T-Mobile®, AT&T, Alltel, ACS Wireless, Bluegrass Cellular, Carolina West Wireless, CellCom, Cellular One of East Central Illinois (ECIT), Cincinnati Bell, Cricket, C-Spire Wireless, Duet IP (aka Max/Benton/Albany), Element Mobile, Epic Touch, GCI Communications, Golden State, Hawkeye (Chat Mobility), Hawkeye (NW Missouri Cellular), Illinois Valley Cellular (IVC), Inland Cellular, iWireless, Keystone Wireless (Immis/PC Management), MetroPCS, MobiPCS, Mosaic, MTPCS/Cellular One (Cellone Nation), Nex-Tech Wireless, nTelos, Panhandle Telecommunications, Pioneer, Plateau, Revol Wireless, Rina-Custer, Rina-All West, Rina-Cambridge Telecom Coop, Rina-Eagle Valley Comm, Rina-Farmers Mutual Telephone Co, Rina-Nucla Nutria Telephone Co, Rina-Silver Star, Rina-South Central Comm, Rina-Syringa, Rina-UBET, Rina-Manti, Simmetry, South Canaan/CellularOne of NEPA, Thumb Cellular, Union Wireless, United Wireless, U.S. Cellular, Viaero Wireless, Virgin Mobile, and West Central Wireless (includes Five Start Wireless). By agreeing to these Takeda Patient Support Program (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. You can unsubscribe from receiving text messages by texting STOP. You will remain enrolled in the Takeda Patient Support Program. For questions about this Program, text HELP or contact the customer support center at 888-229-8379.

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.

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)* _____

Takeda

©2026 Takeda Pharmaceuticals U.S.A., Inc. 1-877-TAKEDA-7 (1-877-825-3327). 500 Kendall Street, Cambridge, MA 02142. All rights reserved. Takeda, Takeda and Patient Support are trademarks or registered trademarks of Takeda Pharmaceutical Company Limited. ADYNOVATE, ADVATE, FEIBA, and RIXUBIS are registered trademarks of Baxalta Incorporated.