Takeda Patient Support For Livtencity

LIVTENCITY® (maribavir)

PATIENT START FORM

TAKEDA PATIENT SUPPORT: YOUR SOURCE FOR EDUCATION AND ACCESS

Takeda Patient Support helps eligible patients with their LIVTENCITY prescription.
We can assist with product access, educational resources, and financial assistance.

CHOOSE 1 OF 3 METHODS TO SUBMIT & ENROLL IN TAKEDA PATIENT SUPPORT

A Fax — Fax the Start Form to **1-855-268-1826** to submit **BOTH** the LIVTENCITY prescription and Takeda Patient Support enrollment.

B Online — Visit **tps-hcp.iassist.com** or scan the QR code to complete the Start Form. **Submit 2-3 documents:** the online Start Form and LIVTENCITY prescription(s) for designated doses via fax or e-prescription.

ONLINE START FORM

C iAssist — Use **hcp.iAssist.com** to submit **BOTH** the LIVTENCITY prescription(s)/prior authorization(s) and Takeda Patient Support enrollment. Obtain electronic updates regarding your patient's status through this portal, eliminating the need for phone calls.

A Continue reading to complete and submit the LIVTENCITY Start Form via fax

Important: complete all fields. If any required information is missing, Takeda Patient Support or the in-network specialty pharmacy will contact the healthcare provider via fax or phone, and/or your patient by phone, depending on the need. Encourage your team and patient to save the following phone numbers in their contacts to avoid mistaking them for spam:

Takeda Patient Support	Amber Specialty Pharmacy	Biologics Specialty Pharmacy
1-855-268-1825	1-888-370-1724	1-866-827-8183

Check for COMMON ERRORS on the Start Form before you submit via fax

- ☐ **In Box 5A (page 3), under Prescription Information, did you select Standard Prescription or Adjusted/Custom Dose and enter the quantity and refills?** This is required and serves as the LIVTENCITY prescription.
- ☐ **In Box 5B (page 3), under Prescription Information, did you fill out all required information if requesting Quick Start (helps eligible patients who are experiencing insurance delays get immediate access to 7 days of LIVTENCITY[a,b])?**
- ☐ **Did your patient or their legal representative sign on pages 4 and 5 and initial boxes on page 5?** This serves as their HIPAA authorization and consent for Takeda Patient Support enrollment. There are several ways patients can provide consent:

In-person:	Via text:	Online:
Patient signs during their appointment	Patient texts "YES" to **1-844-972-4268**	Patient provides at **tps.iassist.com/welcome**

If consent is not given in one of the ways listed above, Takeda Patient Support will call your patient.
Only patients who provide consent can be enrolled in Takeda Patient Support.

[a]Must meet eligibility requirements. [b]Additional terms and conditions may apply.

Takeda Patient Support For Livtencity

LIVTENCITY® (maribavir)

PATIENT START FORM

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

Call Takeda Patient Support at:
1-855-268-1825, Monday-Friday, 8:30 AM to 8:00 PM ET

STEPS TO ENROLL YOUR PATIENT VIA FAX

SECTIONS 1-3: Please provide your patient's information.
SECTIONS 4-5: Please provide prescriber and prescription information.
SECTION 6: Please sign.
SECTION 7: Have your patient sign and initial their consent.

ALL FIELDS MARKED * ARE REQUIRED.

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	
* ADDRESS			
* CITY	* STATE	* ZIP CODE	EMAIL ADDRESS
* PATIENT PREFERRED LANGUAGE		* PATIENT PREFERRED CONTACT METHOD ☐ PHONE ☐ TEXT ☐ EMAIL	
CAREGIVER LEGAL NAME		CAREGIVER PRIMARY PHONE ☐ HOME ☐ WORK ☐ CELL	
RELATIONSHIP TO PATIENT			

†Takeda and its partners acknowledge that patients may identify outside traditional male or female categories. However, many insurance companies require a binary gender selection. We kindly ask you to provide the gender recorded with the patient's insurance, while understanding it may not fully reflect their true identity.

2 PATIENT INSURANCE INFORMATION – please attach copies of both sides of patient's insurance card(s)

* PRIMARY INSURANCE		☐ PATIENT DOES NOT HAVE INSURANCE (leave remaining fields blank if no insurance)	* INSURANCE PHONE
* POLICY ID #		* GROUP #	
* POLICY HOLDER NAME (FIRST, LAST)		* RELATIONSHIP TO PATIENT	* POLICY HOLDER DOB (MM/DD/YYYY)
SECONDARY INSURANCE			SECONDARY 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 the Patient Assistance Program. Additional documentation may be required and additional eligibility requirements apply.

Takeda Patient Support For Livtencity

LIVTENCITY® (maribavir)

PATIENT START FORM

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

Call Takeda Patient Support at:
1-855-268-1825, Monday-Friday, 8:30 AM to 8:00 PM ET

ALL FIELDS MARKED * ARE REQUIRED.

SECTIONS 4 AND 5: PLEASE PROVIDE PRESCRIBER AND PRESCRIPTION INFORMATION. SECTION 6: PLEASE SIGN.

PATIENT INFORMATION

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

†Takeda and its partners acknowledge that patients may identify outside traditional male or female categories. However, many insurance companies require a binary gender selection. We kindly ask you to provide the gender recorded with the patient's insurance, while understanding it may not fully reflect their true identity.

4 PRESCRIBER INFORMATION

* PRESCRIBER NAME	* PRACTICE NAME	HOSPITAL AFFILIATION	* NPI

* PRACTICE ADDRESS	* CITY	* STATE	* ZIP CODE

* ENROLLMENT FORM CONTACT	CONTACT TITLE	PRIOR AUTHORIZATION SUBMITTED? ☐YES ☐NO

* CONTACT PHONE (DIRECT LINE) ☐ CELL ☐ OFFICE	* CONTACT FAX	* CONTACT EMAIL

5 PRESCRIPTION INFORMATION — Complete sections A and/or B depending on prescription needs

A. STANDARD PRESCRIPTION (USED BY THE PATIENT'S SPECIALTY PHARMACY)

Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 2 tablets PO BID **Qty:** _____ **Refills:** _____

ADJUSTED DOSE: 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:** _____	**Refills:** _____
Phenobarbital	Dispense: LIVTENCITY® (maribavir) 200 mg	☐ **SIG:** 6 tablets PO BID	**Qty:** _____	**Refills:** _____
Phenytoin	Dispense: LIVTENCITY® (maribavir) 200 mg	☐ **SIG:** 6 tablets PO BID	**Qty:** _____	**Refills:** _____

CUSTOM DOSE: Dispense: LIVTENCITY® (maribavir) 200 mg ☐ _____ **Qty:** _____ **Refills:** _____

☐ **CHECK BOX FOR NASOGASTRIC/OROGASTRIC (NG/OG) TUBE ADMINISTRATION**

B. QUICK START PROGRAM

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

Is prescription for an FDA-approved indication? ☐ Yes ☐ No ☐ Unsure
If unsure, Takeda Patient Support will investigate eligibility.

ADJUSTED DOSE: 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

☐ **CHECK BOX FOR NASOGASTRIC/OROGASTRIC (NG/OG) TUBE ADMINISTRATION**

* DX CODE: TYPE OF TRANSPLANT: ☐ Medication List/Clinical Documentation attached

PREFERRED SPECIALTY PHARMACY: ☐ AMBER SPECIALTY PHARMACY ☐ BIOLOGICS, INC. ☐ OTHER:

HCP SIGN HERE

* PRESCRIBER SIGNATURE (requires handwritten signature)	* DATE (MM/DD/YYYY)

6 PRESCRIBER SIGNATURE for patient enrollment – including Quick Start Program, if applicable

- 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.

HCP SIGN HERE

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

Takeda Patient Support For Livtencity

LIVTENCITY® (maribavir)

PATIENT START FORM

Enroll through one of the following methods:

FAX: 1-855-268-1826 tps-hcp.iassist.com | iAssist.com

Call Takeda Patient Support at:
1-855-268-1825, Monday-Friday, 8:30 AM to 8:00 PM ET

ALL FIELDS MARKED * ARE REQUIRED.

SECTION 7 : HAVE PATIENT SIGN AND INITIAL THEIR CONSENT ON PAGES 4 AND 5.

PATIENT INFORMATION

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

†Takeda and its partners acknowledge that patients may identify outside traditional male or female categories. However, many insurance companies require a binary gender selection. We kindly ask you to provide the gender recorded with the patient's insurance, while understanding it may not fully reflect their true identity.

7 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 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.

I have read, understand, and agree to the release of my protected health information as described above.

PATIENT SIGN HERE

* PATIENT AUTHORIZATION PATIENT / LEGAL GUARDIAN SIGNATURE	* DATE (MM/DD/YYYY)

Takeda Patient Support For Livtencity

LIVTENCITY® (maribavir)

PATIENT START FORM

Enroll through one of the following methods:

FAX: 1-855-268-1826 tps-hcp.iassist.com | iAssist.com

Call Takeda Patient Support at:
1-855-268-1825, Monday-Friday, 8:30 AM to 8:00 PM ET

ALL FIELDS MARKED * ARE REQUIRED.

PATIENT INFORMATION

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

†Takeda and its partners acknowledge that patients may identify outside traditional male or female categories. However, many insurance companies require a binary gender selection. We kindly ask you to provide the gender recorded with the patient's insurance, while understanding it may not fully reflect their true identity.

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).

PATIENT SIGN HERE

I have read, understand, and agree to the use of my personal information for the purposes described above.

* PATIENT SUPPORT ENROLLMENT PATIENT / LEGAL GUARDIAN SIGNATURE	* DATE (MM/DD/YYYY)

PLEASE PROVIDE ACKNOWLEDGMENT/CONSENT TO THE FOLLOWING BY INITIALING THE BOXES BELOW

PAP FINANCIAL INFORMATION (for PAP eligibility determination only):

INITIAL HERE ☐ 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

☐ 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

INITIAL HERE ☐ 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 Term & 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

INITIAL HERE ☐ 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.

LIVTENCITY® and ▲ are registered trademarks of Takeda Pharmaceuticals International AG. Takeda®, Takeda, and Patient Support are trademarks or registered trademarks of Takeda Pharmaceutical Company Limited. ©2026 Takeda Pharmaceuticals U.S.A., Inc. All rights reserved. US-MAR-0734v3.0 05/26