Takeda Oncology
Here2Assist®

Enrollment Form

Takeda Oncology Here2Assist® is a **comprehensive support program** committed to helping patients navigate **coverage requirements**, identify available **financial assistance**, and connect with helpful resources throughout their treatment.



Models are used for illustrative purposes only.

Questions about enrolling in our support program? **We have the answers.**

Let's Talk. Call us at 1-844-817-6468, Option 2. We're available Monday–Friday, 8AM–8PM ET.

Enroll Online at **www.Here2Assist.com**

Patients who are prescribed **ALUNBRIG® (brigatinib)**, **FRUZAQLA® (fruquintinib)**, **ICLUSIG® (ponatinib)**, or **NINLARO® (ixazomib)**, are eligible to enroll in this program.

Please see accompanying ICLUSIG® full Prescribing Information, including Boxed Warning.

Takeda Oncology Here2Assist®



Scan QR code for online enrollment

Models are used for illustrative purposes only.

There are 2 ways to enroll a patient in Takeda Oncology Here2Assist®

1. You may enroll online by scanning the QR code or visiting takeda.dep.cardinalhealth.com

2. You can enroll by filling out this form together with your patient and faxing to **1-844-269-3038**. Please see the instructions below:

- **COMPLETE ALL INFORMATION** in its entirety with your patient, including product selection, prescriber information, patient information, current insurance information, statement of medical necessity, pharmacy preference, and prescription request.
- **SIGN AND DATE** the form. Prescriber and patient (or legal representative) authorization is required in the form of an original signature following review of the prescriber authorization and the patient authorization sections. A patient's (or legal representative's) original signature is also required on the program enrollment section.

IMPORTANT: Original signatures are required.
Please ensure original signatures for the prescriber and patient (or legal representative) are applied. Stamped signatures will not be accepted. Applications that do not include original signatures cannot be processed, and your patient's enrollment may be delayed.

IMPORTANT: The prescription is valid only if received by fax.

NOTE: Please do not send patient medical records or any other documentation that has not been requested.

What to expect after enrollment

After your patient's Enrollment Form is received and processed, a Takeda Oncology Here2Assist Case Manager will conduct a benefits verification to determine the patient's prescription coverage and potential out-of-pocket costs. A benefits verification will be completed by Takeda Oncology Here2Assist within 1 business day(s).*

Takeda Oncology Here2Assist offers additional support

For patients who are uninsured or have insurance but are not covered for the prescribed Takeda Oncology medication, Takeda Oncology Here2Assist may offer additional support. Learn more about the **Patient Assistance Program**† at **www.Here2Assist.com** or call **1-844-817-6468**, Option 2.

Let's Talk. For more information, call us at 1-844-817-6468, Option 2, or visit www.Here2Assist.com. We're available Monday–Friday, 8AM–8PM ET.

*Verification of benefits is not a guarantee of payment and does not take the place of written policy information.
†Separate program enrollment is required. Terms and Conditions apply.

Takeda Oncology Here2Assist®

Fax to 1-844-269-3038 or **call** 1-844-817-6468,
Option 2, Monday-Friday, 8AM-8PM ET

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PRODUCT (please select one)

Is the patient hospitalized?
☐ **Yes** ☐ **No**

☐ **ALUNBRIG®** (brigatinib)
☐ **ICLUSIG®** (ponatinib)
☐ **NINLARO®** (ixazomib)
☐ **FRUZAQLA®** (fruquintinib)

Please see accompanying ICLUSIG® full Prescribing Information, including Boxed Warning.

PRESCRIBER INFORMATION

Name (First, Middle, Last): _____ Practice Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Primary Office Contact: _____
Primary Office Contact Email: _____
State License #: _____ NPI: _____ Medicare/Medicaid Provider #: ____ Reimbursement Contact: _____

PATIENT INFORMATION

Name (First, Middle, Last): _____ Preferred Name: _____
Preferred Language: _____ Date of Birth (MM/DD/YYYY): _____ Gender*: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ OK to leave a message? ☐ Yes ☐ No Email: _____
Mobile: _____ OK to leave a message? ☐ Yes ☐ No

CARE PARTNER INFORMATION

Please complete this section if you would like Takeda Oncology Here2Assist® to communicate about the program primarily with your care partner on your behalf.

Name: _____ Relationship: _____
Phone: _____ OK to leave a message? ☐ Yes ☐ No Email: _____
Mobile: _____ OK to leave a message? ☐ Yes ☐ No

CURRENT INSURANCE INFORMATION

☐ Check if patient does not have insurance

Please attach copies of both sides of the patient's insurance card(s). Include both medical and pharmacy information if available.

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private/Commercial ☐ Other: _____

Does your patient have Veterans Administration benefits? ☐ Yes ☐ No

Does your patient belong to a federally recognized tribe? ☐ Yes ☐ No

Is your patient on disability? ☐ Yes ☐ No Does your patient have Medicare? ☐ Yes ☐ No

Primary Insurer Name: _____ Insurer Phone: _____
Policy Holder Name (First, Middle, Last): _____ Policy Holder Date of Birth (MM/DD/YYYY): _____
Policy ID #: _____ Group #: _____ Rx BIN #: _____ Rx PCN #: _____
Secondary Insurer Name: _____ Insurer Phone: _____
Policy Holder Name (First, Middle, Last): _____ Policy Holder Date of Birth (MM/DD/YYYY): _____
Policy ID #: _____ Group #: _____ Rx BIN #: _____ Rx PCN #: _____
☐ Patient's insurance is pending with (include name of insurer here): _____

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

Enrollment Form

STATEMENT OF MEDICAL NECESSITY

ICD-10 Code: _____

PHARMACY PREFERENCE (select one)

☐ Specialty Pharmacy Name:_____ ☐ In-office dispensing ☐ No pharmacy preference

For a list of Takeda Oncology Here2Assist® network specialty pharmacies, visit **www.Here2Assist.com/hcp/distribution-and-fulfillment**.

PRESCRIPTION REQUEST: To permit medication to be sent to your patient, the prescription information must be complete and accurate.

Patient Name (First, Middle, Last):_____ Patient Date of Birth (MM/DD/YYYY):_____

PRODUCT (select one)	DOSAGE	DIRECTIONS	DISPENSE	REFILLS (please select)
☐ **ALUNBRIG® (brigatinib) tablets**	**Initiation pack (for new patient starts only)** ☐ 90 mg orally once daily for 7 days, then 180 mg orally once daily for 23 days. *Fill out dosing instructions for subsequent brigatinib refills below.*			
	Subsequent refills ___ mg		___ -day supply	☐ 1 ☐ 2 ☐ 3 ☐ Other ___
☐ **FRUZAQLA® (fruquintinib) capsules**	___ mg		___ -day supply	☐ 1 ☐ 2 ☐ 3 ☐ Other ___
☐ **ICLUSIG® (ponatinib) tablets**	___ mg		___ -day supply	☐ 1 ☐ 2 ☐ 3 ☐ Other ___
☐ **NINLARO® (ixazomib) capsules**	___ mg		___ -day supply	☐ 1 ☐ 2 ☐ 3 ☐ Other ___

PRESCRIBER AUTHORIZATION

By signing this form, I certify that the treatment selected above is medically necessary for the patient identified in this application ("Patient") and the information provided is current, complete, and accurate to the best of my knowledge. By my signature, I also acknowledge that I have received from Patient, or their personal representative, the necessary authorization to release, in accordance with applicable federal and state laws/regulations, the referenced medical and/or other patient information relating to the above-prescribed treatment to Takeda Pharmaceuticals U.S.A., Inc., including its present and future affiliates, business partners, agents and contractors, for the purpose of assisting the patient in obtaining coverage for the above-prescribed treatment and/or to assist the patient in initiating or continuing the above-prescribed treatment. I certify that the prescription complies with all applicable local and state laws. I authorize Takeda Oncology Here2Assist to convey this prescription to the dispensing pharmacy.

SIGN HERE **Prescriber Signature:** (no stamp allowed) _____ **Date:** _____

ATTENTION New York State Prescribers: Prescribers in New York State must submit the prescription on an original New York State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank if applicable for your state.

NOTE: Patient authorization is required to enroll in Takeda Oncology Here2Assist. If Patient authorization is not obtained prior to submission of the enrollment form, the prescriber authorizes Takeda to email the patient for completion.

PATIENT AUTHORIZATION FOR TAKEDA ONCOLOGY HERE2ASSIST®

I understand that Takeda Oncology Here2Assist is a prescription assistance service offered by Takeda Pharmaceuticals U.S.A., Inc. ("Takeda") to help eligible patients who have been prescribed Takeda Oncology medication obtain financial assistance and access other patient support programs provided by Takeda Oncology Here2Assist.*

By signing the Patient Authorization section of this Takeda Oncology Here2Assist Enrollment Form, I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Providers") to disclose my Protected Health Information (as defined under HIPAA and applicable laws and regulations), including personal information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Information"), to Takeda Pharmaceuticals USA, Inc., its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "Takeda") in connection with the Company's provision of products, supplies, services or research opportunities. I may be informed of optional research opportunities that are separate from these products, supplies, or services. Participation is voluntary and would require separate, study-specific consent. I understand the Company will provide this Information to a specialty pharmacy to fulfill the prescription. This Information may also be used for internal uses by the Company, including program administration, quality improvement, and aggregated or de-identified data analysis. Further, I understand that my physician, health insurance, and pharmacy providers may receive financial remuneration from the Company for services related to administering the Here2Assist program, including reimbursement support and care coordination. Such compensation is not provided in exchange for the use or disclosure of my Information for marketing purposes. My Information will only be used and disclosed as necessary to provide program services, in accordance with applicable privacy laws and regulations.

Further, by providing my explicit consent, the Company may use this Information for Takeda Oncology Here2Assist Patient Support Program Services ("Services") (if I agree below) such as 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, fax, text, or telephone about my medical condition, treatment, care management, product information and health insurance.

I understand that once disclosed to the Company, my Personal Health Information disclosed under this Patient Authorization may no longer be protected by applicable privacy laws and regulations, including Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Patient Authorization at any time in the future by calling 1-844-817-6468 or by sending written notice of revocation to Takeda Oncology Here2Assist Patient Support Program, 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from today's date, 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 Oncology Here2Assist Patient Support Program products, supplies, or services.

*Restrictions apply.

Patient Authorization for Takeda Oncology Here2Assist

I have read, understand, and agree to the release of my Protected Health Information as described above.

SIGN HERE **Patient Signature:** _____ **Date:** _____

I certify that I have been personally selected by the patient as their legal representative.

Legal Representative Signature: _____ **Relationship:** _____ **Date:** _____

Enrollment Form

TAKEDA ONCOLOGY HERE2ASSIST® PATIENT SUPPORT PROGRAM ENROLLMENT

Patient Support Program Enrollment

I am electing to enroll in the Services and direct all disclosures of my Information in connection with such Services (which may include, but is 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, fax, text, or telephone about my medical condition, treatment, care management, product information and health insurance).

Text Communication Enrollment for Patient Support Program Services

I consent to receive recurring automated text messages from the Takeda Oncology Here2Assist Patient Support Program including service updates, enrollment support, refill reminders and educational messages to the provided mobile number. Message and data rates may apply. Message frequency varies. Text HELP for help. Text STOP to opt out. Consent to receiving SMS messages is not a condition of purchase of goods or services. Please see the terms and conditions for text communications below and at www.here2assist.com/textingprogram and Takeda's Privacy Notice (https://www.takeda.com/privacy-notice/).

- ☐ **Yes, opt me in. Mobile Phone Number:** _____
- ☐ **No, I do not consent to receiving text communications**

Consent for Marketing and Use of De-Identified Data

By checking this box, I authorize the use of my Contact 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 further authorize the program to de-identify my health information and use it in performing research, including linkage with other de-identified information the program receives from other sources, education, business analytics, marketing studies, or for other commercial purposes provided such information is maintained in de-identified form and will not be used to identify me. I understand that my health information will be de-identified and may be used for ongoing basis and will not be used to identify me.

- ☐ **Yes, opt me in**
- ☐ **No, I do not consent to receiving marketing and promotional communications**

Takeda Oncology Here2Assist Patient Support Program Enrollment

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

SIGN HERE **Patient Signature:** _____ **Date:** _____

I certify that I have been personally selected by the patient as their legal representative.

Legal Representative Signature: _____ **Relationship:** _____ **Date:** _____

TEXT COMMUNICATION AGREEMENT TERMS AND CONDITIONS (OPTIONAL)

Takeda Oncology Here2Assist Patient Support Program text messages are recurring automated program messages, which may include service updates, enrollment support, refill reminders and educational messages. By agreeing to these Takeda Oncology Here2Assist (the "Program") text message terms and conditions, you agree to receive text messages on your mobile device subject to the Terms & Conditions: You also consent to receive autodialed and/or prerecorded 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. For questions about this Program, text HELP or contact the customer support center at 1-844-817-6468. Message frequency varies. Such messages are nonmarketing messages related to the Patient Support Program. 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. 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, carrier information related to your participation in the Program 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. No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. We are able to deliver on most of the major US and minor carriers. If you are unsure whether your carrier supports short codes, please contact your wireless provider directly. Carriers are not liable for delayed or undelivered messages. For additional information regarding Takeda's use of your information, please visit (https://www.takeda.com/privacy-notice/) for additional information.

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