Help At Hand

Patient Assistance Within Reach

Takeda

Takeda Help At Hand
PO Box 5727, Louisville, KY 40255-0727
Phone: 1-800-830-9159 Fax: 1-800-497-0928

CAN I APPLY?

At Takeda, we believe all patients should have access to the medications prescribed by their healthcare providers. We also understand that some patients may have financial situations that make it difficult to pay for their prescriptions. Help at Hand (the Program) provides assistance for people who have no insurance or who do not have enough insurance and need help getting their Takeda medicines.

All applications are reviewed on a case-by-case basis in accordance with program criteria.

To be eligible, you must:

- Be a resident in the United States
- Not have health coverage, or not have enough coverage to obtain your Takeda medication
- Have a household income equal to or less than 5 times the Federal Poverty Level (for more information on Federal Poverty Levels, visit https://aspe.hhs.gov/poverty-guidelines)
- Not have access to alternate sources of coverage or funding
- Have recently lost your job and are experiencing financial hardship

CHECKLIST FOR SUBMITTING APPLICATION

Patients:

- ☐ Complete Sections 1 and 2
- ☐ Attach current proof of income as outlined in Section 2
- ☐ Provide patient signatures in sections 5 and 6

Providers:

- ☐ Complete both sections 3 and 4
- ☐ Provide the prescriber's signature at the bottom of section 4 (signature can NOT be stamped)
- ☐ Fax or mail the completed application and all documentation to the address above.

After completing all the information above, fax or mail the application to Help at Hand.

NOTE: Failure to include all the information above will result in the application being placed on hold which will delay the review of your application

IMPORTANT: Please go to next page. Call 1-800-830-9159 if you need help.
Help At Hand representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. ET

Application type: ○ Initial ○ Renewal

SECTION 1: PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Email Address: _____

By checking yes below, I authorize Takeda HAH Patient Assistance Program to send text messages to my cell phone to convey important information related to my application status or potential shipments. I understand that standard text messaging rates will apply to any messages received from Takeda HAH Patient Assistance Program. I also understand that I or Takeda HAH Patient Assistance Program may revoke this permission in writing at anytime. I further agree that in the event that my cellphone phone number changes I will inform the program. I authorize receiving program communication via text.

○ Yes ○ No

DOB (*MM/DD/YYYY*): _____ Gender: ○ Male ○ Female U.S. Resident: ○ Yes ○ No

SECTION 2: INSURANCE AND INCOME

Do you have prescription drug insurance from: (*check all that apply*)

☐ None ☐ VA/Military benefits ☐ Health exchange plan ☐ Medicare
(if box is checked please enter your MBI number below)
MBI # _____

☐ Employer supplied/private coverage ☐ Medicaid

Number of people in household* _____ **Household = you, spouse and dependents*

Total yearly household* income: $ _____

Have you received Social Security Disability Income for at least two years? ○ Yes ○ No

To verify your income, please include a copy of one of the following: *Required*

- ☐ Last year's federal income tax return(s) for yourself, your spouse and your dependents
- ☐ Social Security Yearly Benefits Statement (SSA-1099) or
- ☐ All household income statements from the last month

Have you recently lost your job and are experiencing financial hardship? ○ Yes ○ No

If yes, please attach proof of job termination or unemployment.

If these documents do not accurately reflect your current financial status, please send documentation of your current income.

Patient First Name: Patient Last Name: DOB:

SECTION 3: PRESCRIBER INFORMATION

First Name: Last Name: Phone: Fax:

Address: City: State: ZIP Code:

State License Number: NPI #

SECTION 4: PRESCRIPTION INFORMATION

(NJ and NY physicians please attach appropriate prescription)

Allergies: ☐ No Known Allergies

Health Conditions: ☐ None

Current Medications: ☐ None

Product *(Please select and complete ship product to below)*	Strength	Directions	Quantity	Refills *(please select)*
☐ AMITIZA® (lubiprostone) Capsules	_____ mcg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ CARBATROL® (carbamazepine) Extended-Release Capsules	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ COLCRYS® (colchicine, USP) Tablets	0.6 mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ DEXILANT® (dexlansoprazole) Delayed-Release Capsules	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ FOSRENOL® (lanthanum carbonate) Chewable Tablets	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ FOSRENOL® (lanthanum carbonate) Oral Powder	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ INTUNIV® (guanfacine) Extended-Release Tablets	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ KAZANO® (alogliptin and metformin HCl) Tablets	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ LIALDA® (mesalamine) Delayed-Release Tablets	1.2 mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ MOTEGRITY® (prucalopride) Tablets	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ MYDAYIS® (mixed salts of a single-entity amphetamine product) Extended-Release Capsules CII	*Pharmacy pick up only; physician must provide a prescription. Maximum daily dose for 13-17 yrs: 25mg; Maximum daily dose for adults: 50mg*		DEA#:	
☐ NESINA® (alogliptin) Tablets	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ OSENI® (alogliptin and pioglitazone) Tablets	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ PENTASA® (mesalamine) Extended-Release Capsules	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ PREVACID SOLUTAB® (lansoprazole) Delayed-Release Orally Disintegrating Tablets	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ ROZEREM® (ramelteon) Tablets	8 mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ TRINTELLIX® (vortioxetine) Tablets	_____ mg	_____	90-days	◯ 1 ◯ 2 ◯ 3
☐ VYVANSE® (lisdexamfetamine dimesylate) Capsules CII	*Pharmacy pick up only; physician must provide a prescription. Maximum daily dose: 70 mg*		DEA#:	
☐ VYVANSE® (lisdexamfetamine dimesylate) Chewable Tablets CII	*Pharmacy pick up only; physician must provide a prescription. Maximum daily dose: 70 mg*		DEA#:	

Ship Product to ◯ **Physician's Office** ◯ **Patient's Address (If no selection is made, product will be shipped to Patient's Address)**

My signature certifies that prescribed therapy is medically necessary for the subject patient and that I will be supervising the patient's treatments. I certify that the information provided by me on this application is true and accurate.

I certify that my signature encompasses any other doctor in my practice/organization. I certify that there will be no charge back cost to the patient above.

Additionally, I certify that if the product is sent to my office on behalf of the patient, I understand that it must be used for the patient listed on this application, and not to be resold or offered for sale or trade, nor shall the patient nor any third-party payer, Medicare or Medicaid be charged for this product.

Prescriber Signature (*Stamped Signatures NOT ACCEPTED*)

SIGN **X** **Date:**

Patient First Name: Patient Last Name: DOB:

SECTION 5: PATIENT DECLARATIONS

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW

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

Patient Signature/Legal Representative (*indicate relationship*)

The parties agree that this Amendment may be executed and delivered by electronic signatures and that the signatures appearing on this Amendment are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

SIGN **X** _____ **Date:** _____

If signature is of legal representative:

Legal Representative Name: _____ Relationship to Patient: _____

Takeda does not charge patients a fee for its assistance. Takeda is not affiliated with third parties who charge a fee for assistance with enrollment or medication refills. If you are being charged a monthly fee for support from Takeda, the organization billing you is not Takeda and you are being charged for support that Takeda can provide to you directly at no cost.

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK
Red boxes signify required fields

Call 1-800-830-9159 if you need help.

Patient First Name: Patient Last Name: DOB:

SECTION 6: PATIENT AUTHORIZATION

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW

By signing this Patient Authorization, 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., and its present or future affiliates, including the affiliates and service providers that work on Takeda's behalf (the "Companies") in connection with the Help At Hand Patient Assistance Program (the "Program"). The Companies will use my Protected Health Information for the purpose of facilitating the provision of the Program. Specifically, I authorize the Companies to receive, use, and disclose my Protected Health Information in order to enroll me in the Program and contact me, and/or the person legally authorized to sign on my behalf, about the Program.

I understand that employees of the Companies only see my Protected Health Information to administer the Program or as otherwise required or allowed under the law, unless information that specifically identifies me is removed. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, my 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 cancel this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Policy available at www.takeda.us/home/privacy_policy.aspx. I understand that such cancellations 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, 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 support through the Program.

Patient Signature/Legal Representative (*indicate relationship*)

SIGN **X** **Date:**

If signature is of legal representative:

Legal Representative Name: Relationship to Patient:

What happens next? You and/or your healthcare provider will receive an answer from Takeda Help At Hand within five to seven days after we receive your application. **Please call 1-800-830-9159 if you have questions.** Representatives are available Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. Quantity of bottles supplied may vary based on patient prescription.

This program, as well as all Takeda Pharmaceuticals U.S.A., Inc. programs, can be discontinued or changed at any time without notice at the discretion of Takeda Pharmaceuticals America, Inc.

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