

Help At Hand

Patient Assistance Within Reach



Takeda Patient Assistance Program

P.O. Box 5727, Louisville, Kentucky 40255-0727

Phone: 1-800-830-9159 Fax: 1-800-497-0928

HOW DO I APPLY?

- 1. Patients:** Complete Sections 1, 2 and 3. *You must sign Section 3.*

Complete Section 4 if you are enrolled in Medicare Part D, *or* Section 5 if you are eligible but not enrolled in Medicare Part D.

VERY IMPORTANT!

Attach copies of your financial documentation from last year. *See Section 2 for details.*

- 2. Healthcare Provider:** Complete Sections 6 and 7, and fax the signed application with all your documentation to 1-800-497-0928 or mail to the address below.

Takeda Patient Assistance Program
P.O. Box 5727
Louisville, Kentucky
40255-0727

CAN I APPLY?

You are eligible to apply for the Takeda Patient Assistance Program if:

- You are a legal resident in the United States.
- You do not have prescription coverage through private or government programs. *(If you are eligible for or enrolled in Medicare Part D, you may still apply — see Sections 4 and 5 for guidelines.)*
- Your total household income does not exceed:

Persons in Household	Annual Income
1	\$33,510
2	\$45,390
3	\$57,270
4	\$69,150
5	\$81,030

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Medication (generic)

This is the application you should use if you have a prescription for these products:

AMITIZA (lubiprostone)	EDARBYCLOR (azilsartan medoxomil/chlorthalidone)
DEXILANT (dexlansoprazole)	Rozerem (ramelteon)
EDARBI (azilsartan medoxomil)	

IMPORTANT: Please go to next page. Call 1-800-830-9159 if you need help.

Patient Assistance Program representatives are available Monday through Friday, 8:30 a.m. to 6:00 p.m. ET



SECTION 1: PATIENT INFORMATION			
First Name	Last Name	Home Address	
City	State	ZIP Code	Preferred Daytime Phone Number
Social Security Number (or Green Card or Visa Number)		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Date of Birth (MM/DD/YYYY)
U.S. Resident <input type="checkbox"/> YES <input type="checkbox"/> NO	U.S. Veteran <input type="checkbox"/> YES <input type="checkbox"/> NO	Deliver Medication To: <i>Delivery will be to patient unless otherwise indicated.</i> <input type="checkbox"/> PATIENT <input type="checkbox"/> HEALTHCARE PROVIDER	

SECTION 2: INSURANCE AND INCOME	
Do you have prescription drug insurance from: <i>(check all that apply)</i> <input type="checkbox"/> Employer supplied <input type="checkbox"/> Medicare Part D* <input type="checkbox"/> Medicaid <input type="checkbox"/> Military benefits <input type="checkbox"/> VA benefits <input type="checkbox"/> Other <input type="checkbox"/> Private drug coverage <input type="checkbox"/> State assistance <input type="checkbox"/> None	Number of people in household** Total <i>yearly</i> household** income: \$ _____ Have you received Social Security Disability Income for at least two years? <input type="checkbox"/> YES <input type="checkbox"/> NO
IMPORTANT: Do you have a copy of last year's federal income tax return? <input type="checkbox"/> YES <input type="checkbox"/> NO If you marked YES, you must include a copy of last year's federal income tax return(s) for yourself, your spouse and your dependents. If your income has changed significantly, or if you are no longer employed, send a new income statement or proof of unemployment. If you marked NO, you must include a copy of: <input type="checkbox"/> IRS Form 4506T <input type="checkbox"/> Social Security Yearly Benefits Statement (SSA-1099) <i>or</i> <input type="checkbox"/> All income statements from jobs held last year	
* Complete Section 4 if enrolled in a Medicare Part D plan * Complete Section 5 if eligible, but not enrolled in a Medicare Part D plan ** Household = you, spouse and dependents	

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SECTION 3: PATIENT HIPAA AUTHORIZATION AND CERTIFICATION	
PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN BELOW	
<p>I request and authorize my healthcare provider (listed in Section 6) and my health insurance company (if any) to disclose to Takeda Pharmaceuticals America, Inc. (Takeda) and its affiliated companies, or third-party contractors assisting Takeda in connection with the Takeda Patient Assistance Program (Program), all personal information relating to my medical condition, treatment and insurance coverage needed to determine my eligibility and administer my participation in the Program.</p> <p>I may refuse to sign this authorization. If I refuse, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment, or affect my insurance enrollment or eligibility for insurance benefits. I may cancel this authorization at any time by mailing a letter of cancellation to Takeda at the address listed at the top of this application form. If I cancel this authorization, I will no longer be allowed to participate in the Program. Cancelling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed by Takeda, but will not affect disclosures made before that time.</p> <p>I understand that once my personal information is disclosed to Takeda or its contractors, federal privacy laws may no longer protect the information from further disclosure. However, my personal information will not be used or disclosed by Takeda or its contractors for any purpose other than to determine my eligibility and to administer my participation in the Program. This authorization expires at the end of my participation in the Program.</p> <p>I certify that the information on this form is accurate and complete to the best of my knowledge. I agree that Takeda and its contractors may also contact my health insurer to verify my insurance information.</p>	
Patient Signature <i>(Stamped Signatures NOT ALLOWED)</i> X	Date

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK



Patient Name: _____ DOB: _____

SECTION 4: COMPLETE ONLY IF YOU ARE ENROLLED IN MEDICARE PART D

1. I understand that if approved for assistance, I will be able to receive the requested medication from the Takeda Patient Assistance Program (Program) for the remainder of the enrollment calendar year* for which my application was approved.
2. I will not seek the requested medication from my Medicare Part D plan for the remainder of the enrollment calendar year.*
3. I will not seek or accept reimbursement from my Medicare Part D Plan for medication received from the Program.
4. I will 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.
5. I give consent to the Program to disclose my enrollment in the Program as needed to comply with legal and regulatory obligations.
6. I agree to notify the Program immediately, in writing, if my prescription drug coverage changes in any way.

*Enrollment calendar year is the calendar year for which this application is being submitted.

Patient Signature X	Medicare ID# (required)	Date
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SECTION 5: COMPLETE ONLY IF YOU ARE ELIGIBLE FOR MEDICARE PART D – BUT NOT ENROLLED

1. I declare and affirm that I am eligible AND not currently enrolled in a Medicare Part D Plan.
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.

Patient Signature X	Date
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SECTION 6: HEALTHCARE PROVIDER INFORMATION

Last Name	First Name	Clinic Name (if applicable)		
Address		City	State	ZIP Code
State License Number		Phone	Fax	
List all current patient medications below:		Is patient allergic to any medications? <input type="checkbox"/> YES (please list below) <input type="checkbox"/> NO		

SECTION 7: PRESCRIPTION INFORMATION (NJ and NY physicians please attach appropriate prescription)

TAKEDA PRODUCT NAME/STRENGTH	DIRECTIONS	DAYS SUPPLY	REFILLS (circle)		
		90 days	1	2	3
		90 days	1	2	3
		90 days	1	2	3

My signature certifies 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 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.

Healthcare Provider Signature (Stamped Signatures NOT ACCEPTED) X	Date
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IMPORTANT: Please go to next page. Call 1-800-830-9159 if you need help.

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SECTION 8: FINAL CHECKLIST

Before you mail OR have your healthcare provider fax your application, *please make sure:*

- You have completed and signed Sections 1, 2 and 3
- Your healthcare provider has completed and signed Sections 6 and 7
- You have attached copies of your financial papers from last year (see Section 2 for details)
- Medicare Part D patients:
 - complete Section 4 ONLY if you are enrolled in Medicare Part D
 - complete Section 5 ONLY if you are eligible for Medicare Part D – but not enrolled
 - attach a copy of the Social Security Low Income Subsidy (LIS) denial letter, if applicable. Applicants will be referred to LIS when income is less than 135% of Federal Poverty Level (FPL) guidelines:

Applicant's annual income must be limited to:	
Individuals	\$16,755
Married Couples	\$22,695

For further information, applicants can refer to www.socialsecurity.gov or may call 1-800-772-1213 (TTY 1-800-325-0778).

Have your healthcare provider's office fax to:
1-800-497-0928

or

Mail your complete application and other papers to:
TAKEDA PATIENT ASSISTANCE PROGRAM
P. O. BOX 5727
LOUISVILLE, KENTUCKY 40255-0727

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What happens next?

You and/or your healthcare provider will receive an answer from the Takeda Patient Assistance Program 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 8:30 a.m. to 6:00 p.m. ET

Quantity of bottles supplied may vary based on patient prescription.

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