NINLARO 1Point
Enrollment Form

How to Enroll in NINLARO 1Point

Please complete the form in its entirety together with your patient. This is an interactive PDF. You may type your responses directly into the PDF and then print the form. You may also print the form and complete it by hand. Either version may be faxed along with a copy of a valid prescription.

1. Please complete the specialty pharmacy (SP) preference, patient, current insurance, and prescriber information sections on the front of the form.
2. Patient (or patient representative) should be certain to read the Patient Authorization section on the front of the form then print, date, and sign their name.
3. The physician should complete the prescription information for NINLARO® (ixazomib), and sign their name. **NOTE: The form cannot be processed without an original signature. Stamped signatures cannot be accepted.**
4. Please be sure to complete the shipping information.
5. To participate in the NINLARO RapidStart Program please be sure to complete the Optional RapidStart section of the enrollment form.
6. Print and sign the form, and fax it to NINLARO 1Point at 1-844-269-3038.

NINLARO 1Point will contact your office once the benefit verification* is complete and will provide you with a summary of benefits within 2 business days upon receipt of all required information.

To apply for the Patient Assistance Program, please visit NINLARO-hcp.com/1Point

The form cannot be processed without an original signature. Stamped signatures cannot be accepted.

*Verification of benefits is not a guarantee of payment and does not take the place of written policy information.

Please see NINLARO full Prescribing Information.

NINLARO® (ixazomib) capsules
4 mg • 3 mg • 2.3 mg

1Point™

NINLARO 1Point Enrollment Form

Fax To: 1-844-269-3038 or Call 1-844-N1POINT (1-844-617-6468), Monday-Friday, 8AM-8PM ET

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SPECIALTY PHARMACY (SP) PREFERENCE (select one)

❑ SP name: _____ ❑ In-office dispensing ❑ No pharmacy preference

For a list of NINLARO 1Point network SPs, refer to the SP list on the back of the NINLARO 1Point Tool Kit or visit NINLARO-hcp.com/1Point

PATIENT INFORMATION

Name (First, Middle, Last): _____ Date of Birth (MM/DD/YYYY): _____ Gender: ❑ Male ❑ Female

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Phone Type: ❑ Home ❑ Work ❑ Mobile OK to leave message? ❑ Yes ❑ No

PRESCRIBER INFORMATION

Prescriber Name (First, Middle, Last): _____ Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Primary Office Contact: _____

State License #: _____ NPI: _____ Medicaid/Medicare Provider #: _____ Reimbursement Contact: _____

PATIENT AUTHORIZATION FOR NINLARO 1POINT SUPPORT PROGRAMS

I understand that the NINLARO 1Point Program is a prescription assistance service offered by Takeda to help eligible patients who have been prescribed NINLARO® (ixazomib) to obtain financial assistance and access other NINLARO patient support programs.*

I allow my healthcare providers, pharmacy, and health plans to share my personal and medical information with Takeda and its agents and contractors, including NINLARO 1Point ("Takeda"). I allow Takeda to use and share this information: 1) to obtain information on insurance coverage and payment for NINLARO; 2) to establish my eligibility for benefits from my health plan or other programs, upon request; 3) to coordinate prescription fulfillment of NINLARO; 4) to provide adherence reminders and support; 5) to contact me to evaluate therapy, the effectiveness of the program, to conduct market research, and so that I may receive educational, promotional, and/or marketing materials about NINLARO, NINLARO 1Point, or Takeda products and services; and 6) for Takeda's internal business purposes, including quality control. The pharmacy may receive a fee in connection with the disclosure of this information.

If I do not sign this form, I understand my eligibility for health plan benefits and treatment by my doctor will not change but I will not have access to the services available under this program. I am allowed a copy of this signed agreement.

I understand that once my health information has been shared with Takeda, federal privacy laws may no longer protect it. This means that Takeda can give it to others only for the purposes described herein or as required by law. I may also cancel my permission in writing at any time by calling 1-844-N1POINT (1-844-617-6468). If I cancel, Takeda will stop using or sharing my information for the reasons listed herein after the cancellation date (except as required by law to end my participation in the NINLARO 1Point Program), but the cancellation will not affect health information that has already been disclosed in reliance on this authorization before that cancellation date. My written permission ends 10 years from the date I sign it unless a shorter period is required under state laws.

*Restrictions apply.

Patient Signature: _____

Date: _____

CURRENT INSURANCE INFORMATION

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

Insurance Plan: ❑ Medicare ❑ Medicaid ❑ Private/Commercial ❑ Other _____

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 has no insurance ❑ Patient's insurance is pending with (include name of insurer here): _____

Please see NINLARO full Prescribing Information.

NINLARO 1Point Enrollment Form (continued)

Fax To: 1-844-269-3038 or Call 1-844-N1POINT (1-844-617-6468), Monday-Friday, 8AM-8PM ET

NINLARO® (ixazomib) capsules 4 mg • 3 mg • 2.3 mg

1Point™

SHIPPING INFORMATION

Ship to patient's home address indicated above? ❑ Yes ❑ No – Ship to address below **Please note: Product cannot be shipped to a PO box**

Patient Name: _____ Contact Person Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

STATEMENT OF MEDICAL NECESSITY

ICD-10 Code: _____

TO REQUEST A NINLARO® (IXAZOMIB) PRESCRIPTION

In order for us to send medication to your patient, the prescription information must be complete and accurate. NINLARO capsules (check 1):

❑ **4.0 mg** capsule (3 pack); 63020-0080-02 ❑ **3.0 mg** capsule (3 pack); 63020-0079-02 ❑ **2.3 mg** capsule (3 pack); 63020-0078-02

❑ **4.0 mg** capsule (1 pack); 63020-0080-01 ❑ **3.0 mg** capsule (1 pack); 63020-0079-01 ❑ **2.3 mg** capsule (1 pack); 63020-0078-01

Dispense: 28-day supply Dosing Instructions: Take 1 capsule weekly for 3 weeks Refill: _____

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Takeda and its employees or agents to assist the patient in obtaining coverage for NINLARO and/or to assist the patient in initiating or continuing NINLARO therapy. I authorize NINLARO 1Point to convey this prescription to the dispensing pharmacy.

Prescriber Signature (no stamp allowed): _____ Date: _____

Prescription is only valid if received by fax. **Original Signature Required. No Stamps Allowed.** Special Note: New York Prescribers, please submit prescription on an original NY State prescription blank. For all other States, if not faxed, must be on State-specific blank if applicable for your State.

OPTIONAL – NINLARO RAPIDSTART PROGRAM

Complete this additional NINLARO RapidStart Prescription and Certification for insured patients who are receiving their first prescription of NINLARO and are experiencing a delay in insurance coverage. NINLARO RapidStart Program can provide these patients with a 28-day (1-cycle) supply of NINLARO at no charge. Terms and conditions apply.*

Product Name: NINLARO Dosing Instructions: Take 1 capsule weekly for 3 weeks

Rx: ❑ **4.0 mg** capsule (3 pack) ❑ **3.0 mg** capsule (3 pack) ❑ **2.3 mg** capsule (3 pack) Day Supply: 28 days

Ship to patient's home address indicated on front? ❑ Yes ❑ No – Ship to address below **Please note: Product cannot be shipped to a PO box**

Patient Name: _____ Contact Person Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

*The RapidStart Program provides a 28-day (1-cycle) supply of treatment of NINLARO at no charge for eligible patients new to NINLARO experiencing a delay in insurance coverage. There is no purchase obligation by virtue of a patient's participation in the RapidStart Program. Patients must have an on-label prescription for NINLARO consistent with the FDA-approved label for NINLARO and be enrolled in the NINLARO 1Point Program to qualify. Free product for the RapidStart Program will only be available through the RapidStart non-commercial specialty pharmacy. A minimum 7-business day insurance verification is required for patients to be eligible for the RapidStart Program. The program may not be combined with any other offer and is not available to patients whose insurers have made a final determination to deny the patient coverage for NINLARO. Takeda reserves the right to change or end the program at any time. Benefits provided under the program are not transferable.

NINLARO is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.
By signing below, I certify that this prescription is on label and that the patient is new to NINLARO treatment. I have read and understand the RapidStart Program terms and conditions and I agree that I shall not seek reimbursement for any NINLARO dispensed to the patient through the RapidStart Program from any government program or third-party insurer. I further certify that I will not attempt to sell, barter, or return for credit any NINLARO provided under this program. I understand that I am under no obligation to prescribe or purchase NINLARO or any other product manufactured by Takeda, and I certify I have received nothing of value from Takeda or its agents or representatives for prescribing a Takeda product.

Prescriber Signature (no stamp allowed): _____ Date: _____

By signing below and accepting the benefits of the program, I certify that I have not previously been prescribed NINLARO, and I will not seek reimbursement or credit from any insurer, healthcare plan or government program and will not sell or trade NINLARO provided under the program. If I am enrolled in a Medicare Part D plan, I certify that I will not attempt to have this prescription or any cost associated with it counted as any portion of my true out-of-pocket ("TrOOP") cost for prescription drugs calculations.

Patient Signature: _____ Date: _____

Please see NINLARO full Prescribing Information.

Takeda ONCOLOGY