Takeda

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

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 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 should:

- ☐ Be a legal resident in the United States
- ☐ In general, not have health coverage through private or government programs
- ☐ Have a household income equal to or less than 3 times the Federal Poverty Level (for more information on Federal Poverty Levels, visit http://www.aspe.hhs.gov/poverty/index.cfm)
- ☐ Not have access to alternate sources of coverage or funding

Applicants who are not approved for enrollment in the program may have the opportunity to seek an exception to the general program criteria.

CHECKLIST FOR SUBMITTING APPLICATION

- ☐ Complete Sections 1, 2 and 3, including signatures
- ☐ Attach current proof of income as outlined in Section 2
- ☐ Have healthcare provider complete and sign Sections 4 and 5
- ☐ Fax or mail the completed application and all documentation to the address above

USE THIS APPLICATION IF YOU HAVE A PRESCRIPTION FOR ONE OF THESE MEDICATIONS

AMITIZA (lubiprostone)	NESINA (alogliptin)
BRINTELLIX (vortioxetine)	OSENI (alogliptin and pioglitazone)
CONTRAVE (naltrexoneHCl/buproprion HCl)	PREVACID SOLUTAB (lansoprazole orally disintegrating tablet)
DEXILANT (dexlansoprazole)	ROZEREM (ramelteon)
KAZANO (alogliptin and metformin HCl)	

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

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK

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)		☐ MALE ☐ FEMALE	Date of Birth (MM/DD/YYYY)
U.S. Resident ☐ YES ☐ NO	U.S. Veteran ☐ YES ☐ NO	Deliver Medication To: *Delivery will be to patient unless otherwise indicated.* ☐ PATIENT ☐ HEALTHCARE PROVIDER	

SECTION 2: INSURANCE AND INCOME

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

☐ Employer supplied ☐ Medicare Part D ☐ Medicaid
☐ Military benefits ☐ VA benefits ☐ Other
☐ Private drug coverage ☐ State assistance ☐ None
☐ Health exchange plan

Number of people in household*

Total *yearly* household* income: $ _____
*Household = you, spouse and dependents

Have you received Social Security Disability Income for at least two years? ☐ YES ☐ NO

IMPORTANT: Do you have a copy of last year's federal income tax return? ☐ YES ☐ 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:
☐ IRS Form 4506T
☐ Social Security Yearly Benefits Statement (SSA-1099) *or*
☐ All income statements from jobs held last year

I declare and affirm that the information provided by me on this application form is true and accurate. I give consent to the Program to disclose my enrollment in the Program as needed to comply with legal and regulatory obligations. I agree to notify the Program immediately, in writing, if my prescription drug coverage changes in any way.

Patient Signature *(Stamped Signatures NOT ACCEPTED)*	Date
X	

SECTION 3: PATIENT HIPAA AUTHORIZATION AND CERTIFICATION

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN BELOW

I request and authorize my healthcare provider (listed in Section 4) 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.

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.

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.

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.

Patient Signature *(Stamped Signatures NOT ACCEPTED)*	Date
X	

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK

Patient Name: _____ DOB: _____

SECTION 4: 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? ☐ YES *(please list below)* ☐ NO		

SECTION 5: 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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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.

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