Reset Form

Takeda ONCOLOGY | 1Point™

Enrollment Form

Fax to 1-844-269-3038 or **call** 1-844-T1POINT (1-844-817-6468), Option 2, Mon-Fri, 8AM-8PM ET

PRODUCT (select one) ☐ ALUNBRIG® (brigatinib) ☐ ICLUSIG® (ponatinib) ☐ NINLARO® (ixazomib)

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: _____

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

PATIENT INFORMATION

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

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ OK to leave message? ❑ Yes ❑ No Email: _____

❑ Yes ❑ No **I give permission to Takeda to contact me by phone or SMS/text message for the purposes of communicating promotional content related to Takeda products and services. Automatic dialing may be used. Carrier, text, and data rates may apply. I understand that I am not required to provide this consent as a condition of purchasing any goods or services.**

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): _____

Visit www.TakedaOncology1Point.com to learn how the RapidStart Program can help eligible patients experiencing a delay in insurance coverage determination.

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 1Point™ network specialty pharmacies, visit www.TakedaOncology1Point.com

SHIPPING INFORMATION

Ship to patient's home address indicated above? ❑ Yes ❑ No–Ship to address below

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

Address: _____ City: _____ State: _____ ZIP: _____

IMPORTANT: Product cannot be shipped to a PO box.

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

PRODUCT (select one)	DOSAGE	DIRECTIONS	DISPENSE	REFILLS (please select)
❑ **ALUNBRIG® (brigatinib) tablets**	❑ **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.*			
	____ 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 ____

I certify that the above therapy is medically necessary and that the information provided is current, complete, and 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 above-prescribed therapy and/or to assist the patient in initiating or continuing the above-prescribed therapy. I authorize Takeda Oncology 1Point™ 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 prescription on an original NY 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 1Point. If Patient Authorization is not obtained prior to submission of enrollment form, the prescriber authorizes Takeda to email Patient for completion.

PATIENT AUTHORIZATION FOR TAKEDA ONCOLOGY 1POINT

I understand that Takeda Oncology 1Point is a prescription assistance service offered by Millennium Pharmaceuticals 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 1Point. *

I authorize my healthcare providers, pharmacy, and health plans to share my personal and medical information, including information about my insurance, prescriptions, medical condition, and health ("Protected Health Information") with and between Takeda and its present or future affiliates, including the affiliates and service providers that work on behalf of Takeda Oncology 1Point (together the "Takeda Group"), to 1) obtain information on insurance coverage for my medication indicated by my prescribing physician above; 2) establish my eligibility for benefits from my health plan or other programs, upon request; 3) coordinate prescription fulfillment of my medication as indicated by my prescribing physician above; 4) facilitate my access to Takeda Oncology 1Point and additional patient support programs provided by Takeda Oncology 1Point; 5) manage Takeda Oncology 1Point and additional patient support programs provided by Takeda Oncology 1Point; 6) provide me with adherence reminders and support; 7) contact me to evaluate the effectiveness of Takeda Oncology 1Point and other patient support programs provided by Takeda Oncology 1Point; 8) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Takeda Oncology 1Point and additional patient support programs provided by Takeda Oncology 1Point, or other Takeda Oncology products and services; and 9) contact me for Takeda's internal business purposes, including quality control and assessment in connection with Takeda Oncology 1Point and other patient support programs provided by Takeda Oncology 1Point, as well as other Takeda Oncology products and services.

I understand that my pharmacy, health insurers, and third-party vendors may receive remuneration (payment) from the Takeda Group in exchange for processing my Protected Health Information to facilitate prescription assistance service, financial assistance, and/or for providing me with access to support services for the purposes described in this Patient Authorization.

I understand that once my Protected Health Information is disclosed, it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 1-844-T1POINT (1-844-817-6468) or by writing PO Box 4280, Gaithersburg, MD 20885-4280. If I do not sign this authorization, I understand my eligibility for health plan benefits and treatment by my doctor will not change, but I will no longer be eligible to participate in Takeda Oncology 1Point, or additional patient support programs provided by Takeda Oncology 1Point, or other Takeda Oncology programs and services. If I revoke this authorization, the Takeda Group will stop using or sharing my Protected Health Information (except as necessary to end my participation in Takeda Oncology 1Point), but my revocation will not affect uses and disclosures of my Protected Health Information previously disclosed in reliance on this authorization. I understand that this written authorization will remain valid for 5 years from the date of my signature, unless I revoke it earlier, or unless a shorter period is required under state laws. I understand that I may receive a copy of this authorization. *Restrictions apply.

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

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