Takeda Oncology
Patient Assistance Program

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: ______

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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The following information will be used to determine patient eligibility. Patients must meet certain clinical, financial, and insurance coverage criteria.
Please do not send patient medical records or any other documentation that has not been requested.

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): ____________________

STATEMENT OF MEDICAL NECESSITY

ICD-10 Code: ____________________

TREATMENT HISTORY

Previous treatments, if any: ____________________

FINANCIAL INFORMATION

Financial Information: Income documentation attached (1040 IRS Forms, SSI Letter, SSDI, Unemployment, Workers' Compensation, etc.) ❑ Yes ❑ No

Size of Household (including patient): ____________ Annual Gross Household Income:____________

AUTHORIZATION

By signing this form, I certify that the information provided above is current, complete, and accurate to the best of my knowledge. I certify that the prescribed Takeda Oncology medication is medically necessary for this patient. I further certify that I shall not seek reimbursement or credit from any insurer, healthcare plan, or government program nor will I attempt to sell, barter, or return for credit any Takeda Oncology medication provided under this program. I understand that I am under no obligation to prescribe or purchase the prescribed medication 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.

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.

By signing this form and accepting the benefits of the program, I certify that the information I have provided on this form, including information related to my income and insurance status, is truthful and complete. I understand that Takeda, or a vendor used by Takeda to carry out the Patient Assistance Program (PAP), may contact me to verify any information I have provided and that my participation in the program will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I certify I will not seek reimbursement or credit from any private insurer or government healthcare program for the Takeda Oncology medication provided under the PAP, nor will I sell or trade the Takeda Oncology medication provided under the PAP. 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") calculations. I acknowledge and understand that I am under no obligation whatsoever to purchase my prescribed Takeda Oncology medication or any other product manufactured by Takeda either before or after the prescribed Takeda Oncology medication is provided to me under the PAP. I understand that Takeda may modify or end the PAP at any time.

SIGN HERE **Patient Signature:** ____________________ Date: ____________

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06/18 MAT-US-XMP-18-00039