TAKHZYRO (lanadelumab-flyo) injection OnePath

OnePath® START FORM: AUTHORIZATION FOR OnePath SERVICES

Fax pages 1 and 3 to 1-855-ONEPATH (1-855-663-7284)

Phone: 1-866-888-0660

1. Patient Information

Name (First, Middle Initial, Last)

M F Male/Female

DOB: Month/Day/Year

Age (Years)

Email Address

Street Address

City

State

ZIP Code

Mobile Telephone (M)

Work Telephone (W)

Home Telephone (H)

M W H Preferred Form of Contact

Legal Representative Name (First, Last), if applicable

Legal Representative Relationship to Patient, if applicable

Legal Representative Telephone, if applicable

2. Insurance Information

Please attach copies of both sides of patient's insurance card(s)

☐ Check if patient does not have insurance

Primary Insurance

Insurance Telephone

Policy ID #

Group ID #

Policy Holder Name (First, Last) and Relationship to Patient

Policy Holder DOB: Month/Day/Year

Pharmacy Plan Name

Pharmacy Plan Telephone

Policy ID #

Group #

Rx BIN #

Rx PCN #

Secondary Insurance

Secondary Insurance Telephone

Secondary Policy ID #

Secondary Group ID #

Policy Holder Name (First, Last) and Relationship to Patient

Policy Holder DOB: Month/Day/Year

3. Prescribing Physician Information

Name (First, Last)

Site Name

Street Address

City

State

ZIP Code

Office Contact

Office Telephone

Fax

State License #

National Provider ID #

4. TAKHZYRO Prescription, Administration, and Prescribing Physician Signature

TAKHZYRO (lanadelumab-flyo) ☐ ICD-10 D84.1 ☐ Other

DOSAGE *(IMPORTANT—ONLY CHECK ONE)*:

☐ One (1) dose [1 vial (2 mL)=300 mg every two (2) weeks. Dispense quantity of 2 vials; 4 weeks' supply]
(FDA label recommended starting dosage)*

☐ One (1) dose [1 vial (2 mL)=300 mg every four (4) weeks. Dispense quantity of 1 vial; 4 weeks' supply]

REFILLS:

☐ 11 months ☐ Other

INJECTION SUPPLIES *(PER DOSE)*:

☐ One (1) empty 3-mL Luer lock syringe and one (1) 18 G transfer needle

☐ One (1) 27 G ½-inch injection needle or other (please specify)

DIRECTIONS:

Self-administer subcutaneous injection as prescribed by your physician in the dosage section.

Special Instructions:

Special Precautions (eg, allergies):

TRAINING:

TAKHZYRO is intended for self-administration or administration by a caregiver. The patient or caregiver should be trained by a healthcare professional. OnePath provides free injection training services to all TAKHZYRO patients.

☐ If you choose to opt out of these services, please check this box.

I appoint Takeda, its affiliates, and their representatives (collectively "Takeda") to convey on my behalf the prescription described herein to a pharmacy, if applicable.

PHYSICIAN CERTIFICATION

By signing this form, I certify that therapy with TAKHZYRO is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current TAKHZYRO Prescribing Information and will be supervising Patient's treatment. I have received from Patient, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state law regulations, referenced medical and/or other patient information relating to TAKHZYRO therapy to Takeda Pharmaceutical Company Limited, including its agents or contractors, for the purpose of seeking information related to coverage and/or assisting in initiating or continuing TAKHZYRO therapy. I authorize OnePath to transmit this prescription to the appropriate pharmacy designated by me, Patient, or Patient's plan. I agree that product provided through the Program shall only be used for Patient, must not be resold, offered for sale or trade or returned for credit.

Prescriber Signature Date

(Stamps not acceptable) (Dispense as written)

*The recommended starting dose is 300 mg every 2 weeks. TAKHZYRO every 4 weeks is also effective and may be considered if the patient is well-controlled (eg, attack free) for more than 6 months.

ADDITIONAL GUIDANCE FOR COMPLETION OF FORM

1. Patient Information

2. Insurance Information

- Fill out completely and fax all forms to OnePath
- Do not submit to Takeda any documentation of lab tests, clinical history, or other documents supporting the prior authorization process

3. Prescribing Physician Information

4. TAKHZYRO Prescription, Administration, and Prescribing Physician Signature

- Please check 1 option for dosage—300 mg every 2 weeks or 300 mg every 4 weeks
- Remember to indicate the number of refills for the patient's prescription

5. Patient Authorization to Share Protected Health Information and OnePath Enrollment

The patient signature is required to allow personal health information to be given by third parties to Takeda to facilitate access to TAKHZYRO (insurance benefits, self-administration training, transfer of Rx to specialty pharmacy provider, etc) as outlined on page 3.

Checking the OnePath enrollment box, as outlined on page 3, allows patients to receive product support services from Takeda, if eligible, including:

- Benefits investigation
- Injection training (if applicable)
- Co-pay support (if applicable) and information about third-party financial assistance programs, as necessary

WHAT HAPPENS NEXT?

1. Once the completed form has been submitted to OnePath, a dedicated Patient Support Manager will be assigned to your eligible patient
2. The Patient Support Manager will contact the patient directly to inform him or her of the services available through OnePath and to begin the insurance verification process
3. The Patient Support Manager will work with the insurance company to determine insurance benefits
    - If applicable, OnePath will assess the patient's eligibility for co-pay support and any other means that will assist the patient in accessing TAKHZYRO
4. The Patient Support Manager will set up Takeda-provided self-administration training services unless you have opted out of these services

INDICATION AND SELECT IMPORTANT SAFETY INFORMATION

TAKHZYRO is indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients ≥12 years of age. Hypersensitivity reactions have been observed. The most commonly observed adverse reactions were injection site reactions. Less common adverse reactions observed included elevated levels of transaminases. Safety and efficacy in pediatric patients <12 years of age have not been established.

For additional Important Safety Information, please see full Prescribing Information.

Patient Name (First, Middle Initial, Last)

DOB: Month/Day/Year

5. Patient Authorization to Share Protected Health Information

I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Providers") to disclose my protected health information, including personal information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Information"), to Takeda Pharmaceutical Company Limited, its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "Takeda") in connection with the Company's provision of products, supplies, or services. I understand the Company will provide this Information to a specialty pharmacy to fulfill the prescription. This Information may also be used for internal uses by the Company, including data analysis. I understand that my Providers may receive financial remuneration from the Company for marketing services.

Further, the Company may use this Information for OnePath Product Support Services (if I agree below) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information and health insurance.

Additionally, if I check the box below regarding marketing communications, I authorize the Company to use and disclose my Information to send marketing materials to me (as described below).

I understand that once disclosed to the Company, my Personal Health Information disclosed under this Authorization may no longer be protected by federal privacy law, including HIPAA. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by sending written notice of revocation to OnePath, 300 Shire Way, Lexington, MA 02421. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from today's date, unless a shorter period is provided for by state law. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way my physician, health insurance, and pharmacy providers treat me. I also understand that if I do not sign this Authorization, I will not be able to receive OnePath Product Support Program products, supplies, or services.

Name (First, Middle Initial, Last)

Patient Signature Date

Legal Representative Name and Relationship (if applicable)

Legal Representative Signature (if applicable) Date

OnePath Enrollment (must check box below to be enrolled in product support services through OnePath)

☐ I am electing to enroll in OnePath Product Support Services ("Services") and direct all disclosures of my Information in connection with such Services (which may include, but is not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information and health insurance).

Consent for Marketing Communications

☐ By checking this box, I authorize the use of my Information for Takeda marketing activities and consent to receiving marketing and promotional communications from Takeda. I hereby give consent to Takeda, its affiliates, and their agents and representatives to send communications and information to me via the contact information I have provided above. I understand that this consent will be in effect until I cancel such authorization.

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