



Mail To: Takeda Pharmaceuticals America, Inc.  
 C/O SDS - PAP - TAK Customer Service  
 P.O. Box 66552  
 St. Louis, MO 63166

Or fax completed forms with prescription to 1-800-497-0928  
 QUESTIONS? CALL 1-800-830-9159

Patient Assistance Program

**SECTION 1 PRACTITIONER INFORMATION (Please print clearly)**

DEA # or State License # (required)		Physician Last Name, First Name	
Office Street Address			
City	State	Zip Code	Phone ( ) Fax ( )
My signature certifies that (1) this patient has demonstrated medical and financial need for assistance and has consented to share, upon request, his or her health and financial information with Takeda Pharmaceuticals America, Inc. ("Takeda") and its contractors to confirm eligibility and to administer participation in the program, and (2) this information is accurate and complete to the best of my knowledge. When product is sent to my office on behalf of the patient, I understand that it must be used for that patient, 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.			
Practitioner's Signature X			Date

**SECTION 2 PATIENT INFORMATION (Please print clearly)**

Note: Upon approval, medications will be sent to the patient address unless otherwise requested

Patient Last Name, First Name		Patient SS, Green Card or Visa #	
Patient Street Address		Patient DOB / /	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male U.S Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
City	State	Zip Code	Phone ( )
List any Patient Allergies:	Are you a Veteran of the US Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number in Household (including self) (circle one) 1 2 3 4 5 6 7 other	

**Have you applied to receive Social Security Disability Benefits?**  Yes  No If yes, when? / /

List any other medications:

**SECTION 3 FINANCIAL AND INSURANCE INFORMATION**

Note: Attach Proof of Income (Examples: Most recent Federal Tax Return, IRS Form 1040, 1040EZ, 4506T, 1099 Social Security or Disability Statements)

<b>List all Sources, Gross Monthly Amounts</b>				<b>PRESCRIPTION DRUG COVERAGE:</b>	
Salary/Wages	\$ _____	Social Security	\$ _____	Private Drug Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Disability	\$ _____	Pension/Retirement	\$ _____	Medicaid (if denied in the past year, please attach denial letter)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployment/Work Comp	\$ _____	Other	\$ _____	Medicare Prescription Drug Program (Including Medicare Part D)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>TOTAL GROSS MONTHLY INCOME:</b> (Total of all columns above) \$ _____					

**Did you file a Federal tax return for the most recent tax year?**  Yes  No

**TOTAL PATIENT ASSETS** (This includes savings/checking, IRA, annuities, stocks/bonds/CDs): \$ \_\_\_\_\_

**SECTION 4 PATIENT HIPAA AUTHORIZATION**

I request and authorize my physician (named above) and my health insurance company (named above, if any) to disclose to Takeda Pharmaceuticals America ("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. Canceling 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.

Signature of Patient or Legal Guardian (1 <sup>st</sup> of 2 patient signatures required) X	Date
------------------------------------------------------------------------------------------------	------

**SECTION 5 PATIENT CERTIFICATION**

I certify that the information on this form is accurate and complete to the best of my knowledge, and that no third party will be charged for product made available under this program. I agree that Takeda and its contractors may also contact my health insurer to verify my insurance information.

Signature of Patient or Legal Guardian (2 <sup>nd</sup> of 2 patient signatures required) X	Date
------------------------------------------------------------------------------------------------	------

DEA # \_\_\_\_\_  
LIC. # \_\_\_\_\_

Date  \_\_\_\_\_

**Patient**

Name \_\_\_\_\_

DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

**Rx**

Qty:

Sig:

\_\_\_\_\_  
( X ) Dispense as Written, signed by provider

Refill \_\_\_\_\_ times

VOID if Not Signed by Provider