BOTH PATIENT AND PRESCRIBER SIGNATURES ARE REQUIRED TO AUTHORIZE THIS FORM.

Takeda Patient Support Start Form: Authorization for Services

Available for patients 1 year of age and older

Takeda Patient Support — Your Source for Education and Access

Gattex® (teduglutide) for injection

FAX THIS FORM TO:
1-855-359-3393
PHONE: 1-855-268-1825

TO BE COMPLETED BY PATIENT

1. PATIENT INFORMATION

Full Name _____

DOB (MM/DD/YYYY) _____ ☐ Male ☐ Female

Email _____

Address _____

City/State/ZIP _____

Primary Phone _____ Secondary Phone _____

Special Precautions (eg, allergies) _____

☐ Español es mi primer idioma

Caregiver (First, Last) _____

Relationship to Patient _____ Phone _____

By providing the names of my other Care Team Members on this form (healthcare providers other than the GATTEX prescribing physician), I am authorizing any employees of the Companies to follow up with these Care Team Members to provide education and information about GATTEX.

HCP Care Team Member† (First, Last) _____

Care Team Role _____ Phone _____

Hospital Information (Name, phone, room #)† _____

†Optional.

2. INSURANCE INFORMATION

REQUIRED: Include copies of both sides of the patient's medical and prescription insurance card(s) ☐ Check if the patient does not have insurance

Primary Insurance _____ Insurance Phone _____

Policy ID # _____ Group _____

Policy Holder Name (First, Last) _____

DOB (MM/DD/YYYY) _____ Relationship to Patient _____

Secondary Insurance _____ Insurance Phone _____

Policy ID # _____ Group _____

Policy Holder Name (First, Last) _____

DOB (MM/DD/YYYY) _____ Relationship to Patient _____

Pharmacy Plan _____ Policy ID # _____ Group # _____

Pharmacy Plan Phone _____ Rx Bin # _____ Rx PCN # _____

3. PRESCRIBING PHYSICIAN INFORMATION

Full Name _____ Treatment Center _____

Address _____

City/State/ZIP _____

Phone _____ Fax _____

Treatment Center Name _____ Office Contact Name _____

Office Contact Phone _____ Office Contact Email _____

National Provider ID _____

4. PATIENT CLINICAL INFORMATION

Diagnosis‡

☐ **New Start**
Short bowel syndrome (SBS) patient dependent on parenteral nutrition and/or IV fluids (parenteral support)

☐ **Existing Patient**
GATTEX renewal

‡Please do not check a box if neither applies.

Date of Last Intestinal Resection _____

ICD-10 Code _____

Etiology

☐ **Inflammatory Bowel Disease (IBD)**
(eg, chronic conditions such as Crohn's disease)

☐ **Non-IBD**
(eg, acute events [vascular event, trauma, intestinal obstruction], congenital anomaly [gastroschisis, midgut volvulus])

Parenteral Support Provider/Pharmacy _____

TO BE COMPLETED BY OFFICE/PHYSICIAN

5. PRESCRIPTION FOR GATTEX (teduglutide) FOR INJECTION

The prescriber must comply with state-specific prescription requirements such as state-specific prescription form, e-prescribing, etc.

STEP 1: Calculate patient dosage (check one box below)

☐ **Dose: 0.05 mg/kg once daily** (5 mg kit is not recommended in patients weighing less than 10 kg)

☐ **Reduce dose to 0.025 mg/kg once daily:** Patient has moderate or severe renal impairment or end-stage renal disease (estimated glomerular filtration rate [eGFR] less than 60 mL/min/1.73 m²)

Complete both calculations

_____ (patient weight (kg)) × _____ (Multiply by 0.05 **OR** 0.025 per above) = _____ (patient dose (mg/day))

_____ (patient weight (kg)) ÷ _____ (Divide by 200 (0.05 dose) **OR** 400 (0.025 dose)) = _____ (volume (mL/day))

STEP 2: Choose # of 30-vial kits needed

If dose is more than 3.8 mg/day, two 30-vial kits are recommended§

☐ **One (1) 30-Vial Kit**/NDC 68875-0102-1/Vial Size: 5 mg

☐ **Two (2) 30-Vial Kits**/NDC 68875-0102-1/Vial Size: 5 mg

§A maximum of 0.38 mL of the reconstituted solution, containing 3.8 mg of teduglutide, can be withdrawn from each vial for dosing.

STEP 3: Enter directions

Administer _____ mg (_____ mL) dose subcutaneously, under the skin, once daily. Number of refills _____

HCP SIGN HERE X _____ _____

*Prescriber Signature (requires handwritten signature) *Date (MM/DD/YYYY)

Authorization for Takeda Patient Support

ALL FIELDS MARKED * ARE REQUIRED.

6. PRESCRIBER SIGNATURE FOR PATIENT ENROLLMENT

- By signing this form, I certify that therapy with GATTEX is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current GATTEX 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 GATTEX therapy to Takeda Pharmaceuticals U.S.A., Inc., including its agents or contractors (the "Company"), for the purpose of seeking information related to coverage and/or assisting in initiating or continuing GATTEX therapy. I authorize Takeda Patient Support 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, and must not be resold, offered for sale or trade, or returned for credit. I understand that I am under no obligation to prescribe GATTEX or any other product manufactured by the Company, and I certify I have received nothing of value from the Company or its agents or representatives for prescribing a Company product.
- I certify that I have reviewed the additional terms available at https://ebvterms.com/terms, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regards to this certification.

HCP SIGN HERE X _____ _____

*Prescriber Signature (requires handwritten signature) *Date (MM/DD/YYYY)

Authorization for Takeda Patient Support

ALL FIELDS MARKED * ARE REQUIRED.

7. PATIENT HIPAA AUTHORIZATION

By signing the Patient Authorization section below, I authorize my physician, health insurance, and pharmacy providers (including any specialty pharmacy that receives my prescription) to disclose my protected health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Protected Health Information"), to Takeda Pharmaceuticals U.S.A., Inc. and its present or future affiliates and their representatives, agents, and contractors, including the affiliates and service providers that work on Takeda's behalf in connection with the Takeda Patient Support Program (collectively the "Companies"). The Companies will use my Protected Health Information for the purpose of facilitating the provision of the Takeda Patient Support Program products, supplies, or services as selected by me or my physician and may include (but not be limited to) verification of insurance benefits and drug coverage, prior authorization education, financial assistance with co-pays, patient assistance programs, alternate funding resources, and other related programs. Specifically, I authorize the Companies to 1) receive, use, and disclose my Protected Health Information in order to enroll me in Takeda Patient Support and contact me, and/or the person legally authorized to sign on my behalf, about Takeda Patient Support; 2) provide me, and/or the person legally authorized to sign on my behalf, with educational materials, information, and services related to Takeda Patient Support; 3) verify, investigate, and provide information about my coverage for GATTEX, including but not limited to communicating with my insurer, specialty pharmacies, and others involved in processing my pharmacy claims to verify my coverage; 4) coordinate prescription fulfillment; and 5) use my information to conduct internal analyses.

I understand that employees of the Companies only use my Protected Health Information for the purposes described herein, to administer the Takeda Patient Support Program or as otherwise required or allowed under the law, unless information that specifically identifies me is removed. Further, I understand that my healthcare provider may receive financial remuneration from Takeda Pharmaceuticals U.S.A., Inc. for marketing services. I understand that once my Protected Health Information is disclosed under this Authorization, it may no longer be protected by federal privacy law. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Notice available at www.takeda.com/privacy-notice/. I can also revoke my Authorization by emailing PrivacyOffice@takeda.com or by calling 1-855-268-1825. I understand that such cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from the date it is signed and provided below, 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 Takeda Patient Support Program products, supplies, or services.

***Patient HIPAA Authorization** **I have read, understand, and agree to the release of my protected health information as described above.**

PATIENT SIGN HERE X _____ _____

Patient signature/legal representative signature (indicate relationship) Date (MM/DD/YYYY)

8. TAKEDA PATIENT SUPPORT ENROLLMENT

By signing below, I am electing to enroll in Takeda Patient Support Services ("Services") and direct all disclosures of my Information in connection with such Services (which may include, but are not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, disease state/product education, 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).

***Takeda Patient Support Enrollment** **I have read, understand, and agree to the release of my protected health information as described above.**

PATIENT SIGN HERE X _____ _____

Patient signature/legal representative signature (indicate relationship) Date (MM/DD/YYYY)

9. TEXT MESSAGING AGREEMENT TERMS & CONDITIONS (OPTIONAL)

By agreeing to these Takeda Patient Support (the "Program") text message terms and conditions, you agree to receive text messages on your mobile device subject to the Term & Conditions described below. You also consent to receive autodialed and/or pre-recorded calls and/or text messages from or on behalf of the Program at the telephone number provided above. You understand that this consent is not a condition of purchase or use of the Program or of any Takeda product or service. Participants will receive an average of 5 text messages each month while enrolled in the Program. Such messages may be nonmarketing messages related to the Patient Support Program. There is no fee payable to Takeda to receive text messages; however, your carrier's message and data rates may apply. You represent that you are the account holder for the mobile telephone number(s) that you provide to opt-in to the Program. You are responsible for notifying Takeda immediately if you change your mobile telephone number. You may notify Takeda of a number change by calling 1-855-268-1825. Data obtained from you in connection with your registration for, and use of, this SMS service may include your phone number and/or email address, related carrier information, and elements of pharmacy claim information and will be used to administer this Program and to provide Program benefits such as information about your prescription, refill reminders, and Program updates and alerts. Takeda will not be liable for any delays in the receipt of any SMS messages, as delivery is subject to effective transmission from your network operator. This Program is valid with most major US cellular providers. Takeda may be required to contact the user if an adverse event is reported. You agree to indemnify Takeda and any third parties texting on its behalf in full for all claims, expenses, and damages related to or caused, in whole or in part, by your failure to immediately notify us if you change your telephone number, including but not limited to all claims, expenses, and damages related to or arising under the Telephone Consumer Protection Act. Takeda reserves the right to rescind, revoke, or amend the Program without notice at any time. You can unsubscribe from this Program by texting STOP to 1-844-972-4268. For questions about this Program, text HELP or contact the customer support center at 1-855-268-1825.

PATIENT INITIAL HERE X _____

10. PATIENT CONSENT FOR MARKETING COMMUNICATIONS (OPTIONAL)

By initialing 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.

PATIENT INITIAL HERE X _____