OnePath® START FORM

OnePath

TAKHZYRO (lanadelumab-flyo) injection

Authorization for OnePath Services

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

Phone: 1-866-888-0660

US-LANA-1111v1.0

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)

Preferred Form of Contact: M W H | 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) 150 mg/mL
One (1) single-dose prefilled syringe 2 mL
(47783-646-01)

☐ ICD-10 D84.1 ☐ Other

DOSAGE *(IMPORTANT—ONLY CHECK ONE)*:

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

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

REFILLS: ☐ 11 months ☐ Other

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

Special Instructions: | Special Precautions (e.g., 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)

*Takeda and its partners recognize that patients may not identify as male or female. However, many insurance companies still require that one of these two fields be used for each of their members. Please indicate the gender on file with the patient's insurance company.

†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 (e.g., 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. The Patient Authorization is also provided in Spanish on page 4 for Spanish-speaking patients.

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

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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.

Takeda

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This text translates to "Once you have read this form, please sign and return the English version for enrollment."
All other content on this page is a direct translation of page 3 of this document.

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La versión en idioma español de la autorización del paciente para compartir información médica protegida tiene fines de traducción únicamente y no puede ser presentada para inscribirse en OnePath. Una vez que haya leído este formulario, firme y envíe la versión en idioma inglés para la inscripción.

5. Autorización del paciente para compartir información médica protegida

Autorizo a cualquier plan de salud, médico, profesional de atención médica, hospital, clínica, proveedor farmacéutico u otro proveedor de atención médica (colectivamente, los "Proveedores") para divulgar mi información médica protegida, incluida la información personal relacionada con mi condición médica, tratamiento, gestión de la atención y seguro médico, así como toda la información proporcionada en este formulario y en cualquier receta (la "Información"), a Takeda Pharmaceutical Company Limited, sus filiales y sus representantes, agentes y contratistas (colectivamente, la "Empresa" o "Takeda") en relación con el suministro de productos, suministros o servicios por parte de la Empresa. Entiendo que la Empresa proporcionará esta Información a una farmacia especializada para completar la receta. Esta Información también puede ser utilizada por la Empresa con fines internos, incluido el análisis de datos. Entiendo que mis Proveedores pueden recibir una remuneración económica de la Empresa por los servicios de marketing.

Además, la Empresa puede utilizar esta Información sobre servicios de asistencia para productos OnePath (si acepto a continuación), como la verificación de los beneficios del seguro y la cobertura de fármacos, asistencia para la autorización previa, asistencia financiera con copago, programas de asistencia al paciente, fuentes de financiación alternativas, otros programas relacionados, comunicaciones conmigo o con mi médico prescriptor por correo postal, correo electrónico o teléfono sobre mi condición médica, tratamiento, gestión de la atención, información del producto y seguro médico.

Además, si marco la casilla siguiente con respecto a las comunicaciones de marketing, autorizo a la Empresa a utilizar y divulgar mi Información para que me envíe materiales de marketing (como se describe a continuación).

Entiendo que, una vez divulgada a la Empresa, es posible que mi Información médica personal divulgada en virtud de esta Autorización ya no esté protegida por la legislación federal sobre privacidad, incluida la HIPAA. Entiendo que tengo derecho a recibir una copia de esta Autorización. Entiendo que puedo cancelar esta Autorización en cualquier momento mediante el envío de una notificación de revocación por escrito a OnePath, 300 Shire Way, Lexington, MA 02421. Entiendo que dicha revocación no se aplicará a ninguna información ya utilizada o divulgada a través de esta Autorización. Esta Autorización caducará en un plazo de cinco (5) años a partir de la fecha actual, a menos que la legislación estatal disponga un periodo más corto. Entiendo que puedo negarme a firmar esta Autorización y que mi negativa no cambiará la forma en que me traten mi médico, el seguro médico y los proveedores de farmacia. También entiendo que si no firmo esta Autorización, no podré recibir productos, suministros o servicios del programa de asistencia para productos OnePath.

Inscripción en OnePath

- Estoy optando por inscribirme en los servicios de asistencia para productos OnePath (los "Servicios") y dirigir todas las divulgaciones de mi Información en relación con dichos Servicios (que pueden incluir, entre otros, la verificación de los beneficios del seguro y la cobertura de fármacos, asistencia previa a la autorización, ayuda financiera con copagos, programas de asistencia al paciente, fuentes de financiación alternativas, otros programas relacionados, las comunicaciones conmigo o con mi médico prescriptor por correo postal, correo electrónico o teléfono sobre mi condición médica, tratamiento, gestión de la atención, información sobre el producto y el seguro médico).

Consentimiento para recibir comunicaciones de marketing

- Al marcar esta casilla, autorizo el uso de mi Información para que Takeda realice actividades de marketing y doy mi consentimiento para recibir comunicaciones de marketing y promocionales de Takeda. Por la presente doy mi consentimiento a Takeda, a sus afiliados, a sus agentes y representantes para que me envíen comunicaciones e información a través de la información de contacto que he proporcionado anteriormente. Entiendo que este consentimiento estará en vigor hasta que cancele dicha autorización.

Takeda

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