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 PAGE 1 OF THIS FORM TO: 1-855-359-3393
PHONE: 1-866-888-0660

TO BE COMPLETED BY PATIENT

1. PATIENT INFORMATION

Full Name _____

DOB (MM/DD/YYYY) _____ Male Female

Last 4 Digits of SSN _____ Email _____

Address _____

City/State/ZIP _____

Primary Phone _____ Secondary Phone _____

Special Precautions (eg, allergies) _____

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 _____

Español es mi primer idioma

*Optional.

I would like to opt in to marketing communications.

Patient Authorization

I have read, understand, and agree to the release of my protected health information, as described on Page 2, Section 6 of this form.

X _____ _____

Patient signature/legal representative signature (indicate relationship) Date

Takeda Patient Support Program and Communications Enrollment

I have read, understand, and agree to the use of my personal information for the purposes described on Page 2, Section 7 of this form.

X _____ _____

Patient signature/legal representative signature (indicate relationship) Date

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 # _____

TO BE COMPLETED BY OFFICE/PHYSICIAN

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 _____

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 m^2)

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 # 68875-0102-01/Vial Size: 5 mg

Two (2) 30-Vial Kits/NDC # 68875-0102-01/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 _____

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 a pharmacy within the GATTEX specialty pharmacy network. I agree that product provided shall only be used for Patient. I understand that I am under no obligation to prescribe or purchase 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.

X _____ _____

Prescriber Signature (Stamps not acceptable; dispense as written) Date

X _____ _____

Prescriber Signature (Substitution permitted) Date

Authorization for Takeda Patient Support

PLEASE READ THROUGH THE LANGUAGE ON THIS PAGE BEFORE SIGNING THE AUTHORIZATION AND CONSENT IN SECTION 1 OF THE START FORM.

6. 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. Further, I understand that my physician, health insurance, and pharmacy providers may receive financial remuneration from the Companies for providing Protected Health Information, which may be used for marketing purposes.

Further, the Company may use this Information for Takeda Patient Support Services ("Services") (if I agree on page 1) 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.

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 Takeda Patient Support, 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 Services from Takeda.

7. TAKEDA PATIENT SUPPORT ENROLLMENT

By signing the Takeda Patient Support Program and Communication Enrollment section on page 1, section 1, I am electing to enroll in the 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).

8. PATIENT CONSENT FOR MARKETING COMMUNICATIONS

By checking the box on page 1, section 1, 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 on page 1. I understand that this consent will be in effect until I cancel such authorization.

Please click here for full Prescribing Information.

Takeda Patient Support
Your Source for Education and Access