Takeda Patient Support For Livtencity

LIVTENCITY® (maribavir)

PATIENT START FORM

TAKEDA PATIENT SUPPORT: YOUR SOURCE FOR EDUCATION AND ACCESS

Takeda Patient Support is here to help eligible patients get their LIVTENCITY as prescribed. We can assist with product access, educational resources, and financial assistance, including:

- Helping expedite delivery of your patient's medication
- Working with your patient's specialty pharmacy
- Connecting your patient to co-pay or insurance help
  - The Takeda Patient Support Co-Pay Assistance Program for LIVTENCITY helps eligible patients pay as little as **$0 per prescription**.* The program covers out-of-pocket expenses related to your patient's prescription, including co-pays, deductibles, and coinsurance. To be eligible for the program, your patient must:
    - Have commercial insurance*
    - Be prescribed LIVTENCITY for the approved indication
  - If your patient has government insurance, we are here to help answer questions about LIVTENCITY coverage. This includes federal or state insurance such as Medicare, Medicare Advantage, or Medicaid. If your patient can't afford treatment, we may be able to connect your patient to programs that may help
- Helping your patient understand their condition and LIVTENCITY

Your patients do not need to be present when completing the Start Form.

Important: Please direct your patients to provide their consent by texting YES to 1-844-972-4268 after you have submitted the Start Form.

3 CONVENIENT WAYS TO ENROLL IN TAKEDA PATIENT SUPPORT:

1. **Fill out** the Start Form online by visiting **tps-hcp.iassist.com** or scanning this QR code:
2. **Visit** the iAssist Platform at **iAssist.com**
3. **Fax** the Start Form to **1-855-268-1826**

Questions?

Call Takeda Patient Support at 1-855-268-1825 Monday-Friday, 8 AM to 8 PM ET.

*IMPORTANT NOTICE: Takeda's Co-pay Assistance Program ("the Program") provides financial support for commercially insured patients who qualify for the Program. Participation in the Program and provision of financial support is subject to all Program terms and conditions, including but not limited to eligibility requirements, the Program maximum benefit per claim and the annual calendar year Program maximum ("Annual Program Maximum"). The Annual Program Maximum for your prescribed Takeda product can be found by visiting: https://www.takedapatientsupport.com/hcp/livtencity/financial_assistance_options.

By enrolling in the Program, you agree that the Program is intended solely for the benefit of you—not health plans and/or their partners. Further, you agree to comply with all applicable requirements of your health plan. The Program cannot be used if the patient is a beneficiary of, or any part of the prescription is covered by: 1) any federal, state, or government-funded healthcare program (Medicare, Medicare Advantage, Medicaid, TRICARE, etc.), including a state pharmaceutical assistance program (the Federal Employees Health Benefit (FEHB) Program is not a government-funded healthcare program for the purpose of this offer), 2) the Medicare Prescription Drug Program (Part D), or if the patient is currently in the coverage gap, or 3) insurance that is paying the entire cost of the prescription. No claim for reimbursement of the out-of-pocket expense amount covered by the Program shall be submitted to any third-party payer, whether public or private.

Some health plans have established programs referred to as 'co-pay maximizer' programs. A co-pay maximizer program is one in which the amount of a patient's out-of-pocket costs is adjusted to reflect the availability of support offered by a manufacturer's co-pay assistance program. If you are enrolled in a co-pay maximizer program, your Annual Program Maximum may vary over time to ensure the program funds are used for your benefit (for the benefit of the patient). Takeda also reserves the right to reduce or eliminate the co-pay assistance available to patients enrolled in an insurance plan that utilizes a co-pay maximizer program.

If you learn your health plan has implemented a co-pay maximizer program, you agree to notify the Program immediately by calling 1-855-268-1825. It may be possible that you are unaware whether you are subject to a co-pay maximizer program when you enroll or re-enroll in the Program. Takeda will monitor program utilization data and reserves the right to discontinue assistance under the Program at any time if Takeda determines that you are subject to a co-pay maximizer, or similar program.

The Program only applies in the United States, including Puerto Rico and other U.S. territories, and does not apply where prohibited by law, taxed, or restricted. This does not constitute health insurance. Void where use is prohibited by your insurance provider. If your insurance situation changes you must notify the Program immediately at 1-855-268-1825. Coverage of certain administration charges will not apply for patients residing in states where it is prohibited by law.

This Program offer is not transferable and is limited to one offer per person and may not be combined with any other coupon, discount, prescription savings card, rebate, free trial, patient assistance, co-pay maximizer, alternative funding program, co-pay accumulator, or other offer, including those from third parties and companies that help insurers or health plan manage costs. Not valid if reproduced.

By utilizing the Program, you hereby accept and agree to abide by these terms and conditions. Any individual or entity who enrolls or assists in the enrollment of a patient in the Program represents that the patient meets the eligibility criteria and other requirements described herein. You must meet the Program eligibility requirements every time you use the Program. Takeda reserves the right to rescind, revoke, or amend the Program at any time without notice, and other terms and conditions may apply.

LIVTENCITY® (maribavir) PATIENT START FORM

Enroll through one of the following contact methods: tps-hcp.iassist.com iAssist.com FAX: 1-855-268-1826

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STEPS TO ENROLL YOUR PATIENT:

SECTIONS 1-3: Please provide your patient's information.

SECTIONS 4 AND 5: Please provide prescriber and prescription information.

SECTION 6: Please sign.

ALL FIELDS MARKED ◌ ARE REQUIRED

1 PATIENT INFORMATION

◌ LEGAL NAME (FIRST, MIDDLE, LAST)		◌ GENDER* ☐ MALE ☐ FEMALE	◌ DATE OF BIRTH (MM/DD/YYYY)
◌ PRIMARY PHONE ☐ HOME ☐ WORK ☐ CELL		◌ SECONDARY PHONE ☐ HOME ☐ WORK ☐ CELL	
◌ ADDRESS			
◌ CITY	◌ STATE	◌ ZIP	EMAIL ADDRESS
◌ PATIENT PREFERRED LANGUAGE		◌ PATIENT PREFERRED CONTACT METHOD ☐ PHONE ☐ TEXT ☐ EMAIL	
CAREGIVER LEGAL NAME		CAREGIVER PRIMARY PHONE ☐ HOME ☐ WORK ☐ CELL	
RELATIONSHIP TO PATIENT			

*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.

2 PATIENT INSURANCE INFORMATION (Please attach copies of both sides of patient's insurance card[s])

◌ PRIMARY INSURANCE		☐ PATIENT DOES NOT HAVE INSURANCE	◌ INSURANCE PHONE
◌ POLICY ID #		◌ GROUP #	
◌ POLICY HOLDER NAME (FIRST, LAST)		◌ RELATIONSHIP TO PATIENT	◌ POLICY HOLDER DOB (MM/DD/YYYY)
SECONDARY INSURANCE			INSURANCE PHONE
POLICY ID #		GROUP #	
POLICY HOLDER NAME (FIRST, LAST)		RELATIONSHIP TO PATIENT	POLICY HOLDER DOB (MM/DD/YYYY)
◌ PHARMACY PLAN NAME		◌ PHARMACY PLAN PHONE	
◌ Rx # ID	◌ Rx GROUP #	◌ Rx PCN #	◌ Rx BIN #

3 PATIENT INCOME INFORMATION†

LAST FOUR DIGITS OF SS #	# OF PEOPLE IN HOUSEHOLD	TOTAL ANNUAL HOUSEHOLD INCOME (BEFORE TAXES)

†The program will leverage soft credit check tools to determine the patient's eligibility for the Patient Assistance Program. Additional documentation may be required and additional eligibility requirements apply.

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PATIENT INFORMATION

◌ LEGAL NAME (FIRST, MIDDLE, LAST)	◌ GENDER* ☐ MALE ☐ FEMALE	◌ DATE OF BIRTH (MM/DD/YYYY)

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4 PRESCRIBER INFORMATION

◌ PRESCRIBER NAME	◌ PRACTICE NAME	HOSPITAL AFFILIATION	◌ NPI

◌ PRACTICE ADDRESS	◌ CITY	◌ STATE	◌ ZIP

◌ CONTACT FOR ENROLLMENT COMMUNICATION	CONTACT TITLE	PRIOR AUTHORIZATION SUBMITTED? ☐YES ☐NO

◌ CONTACT PHONE ☐ CELL ☐ OFFICE	◌ CONTACT FAX	CONTACT EMAIL

5 PRESCRIPTION INFORMATION (To submit electronically, visit tps-hcp.iassist.com)

STANDARD DOSE

Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 2 tablets PO BID

ADJUSTED DOSING: PER LIVTENCITY PRESCRIBING INFORMATION, ADJUSTED DOSING IS RECOMMENDED FOR THE FOLLOWING CONCOMITANT MEDICATIONS:

Carbamazepine
Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 4 tablets PO BID

Phenobarbital
Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 6 tablets PO BID

Phenytoin
Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 6 tablets PO BID

Qty: _____ **Refills:** _____

PLEASE CHECK BOX FOR NASOGASTRIC/OROGASTRIC (NG/OG) TUBE ADMINISTRATION ☐

QUICK START PROGRAM: THIS SECTION IS ONLY REQUIRED IF PATIENT IS ELIGIBLE FOR THIS PROGRAM

STOP ☐ **Patient diagnosis: FDA-approved indication for LIVTENCITY**

Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 2 tablets PO BID
Qty: 28 **Refills:** 1

ADJUSTED DOSING: PER LIVTENCITY PRESCRIBING INFORMATION, ADJUSTED DOSING IS RECOMMENDED FOR THE FOLLOWING CONCOMITANT MEDICATIONS:

Carbamazepine
Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 4 tablets PO BID
Qty: 56 **Refills:** 1

Phenobarbital
Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 6 tablets PO BID
Qty: 84 **Refills:** 1

Phenytoin
Dispense: LIVTENCITY® (maribavir) 200 mg ☐ **SIG:** 6 tablets PO BID
Qty: 84 **Refills:** 1

PLEASE CHECK BOX FOR NASOGASTRIC/OROGASTRIC (NG/OG) TUBE ADMINISTRATION ☐

DX CODE: _____ TYPE OF TRANSPLANT: _____ ☐ Medication List/Clinical Documentation attached

PREFERRED SPECIALTY PHARMACY ☐ AMBER SPECIALTY PHARMACY ☐ BIOLOGICS, INC. ☐ OTHER

SIGNATURE REQUIRED	◌ PRESCRIBER SIGNATURE	◌ DATE (MM/DD/YYYY)

6 PRESCRIBER SIGNATURE FOR PATIENT ENROLLMENT

- By signing this form, I certify that therapy with LIVTENCITY is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current LIVTENCITY 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 LIVTENCITY 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 LIVTENCITY 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 LIVTENCITY 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.

SIGNATURE REQUIRED	◌ PRESCRIBER SIGNATURE	◌ DATE (MM/DD/YYYY)

PATIENT AUTHORIZATION FOR LIVTENCITY® (maribavir)

Enroll through one of the following contact methods: tps-hcp.iassist.com iAssist.com FAX: 1-855-268-1826

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ALL FIELDS MARKED ◌ ARE REQUIRED

PATIENT INFORMATION		
◌ LEGAL NAME (FIRST, MIDDLE, LAST)	◌ GENDER* ☐ MALE ☐ FEMALE	◌ DATE OF BIRTH (MM/DD/YYYY)

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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 LIVTENCITY, 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 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.

SIGNATURE REQUIRED

◌ PATIENT AUTHORIZATION (I have read, understand, and agree to the release of my protected health information as described above)	◌ DATE (MM/DD/YYYY)
PATIENT SIGNATURE	

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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, 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).

SIGNATURE REQUIRED

◌ PATIENT SUPPORT ENROLLMENT (I have read, understand, and agree to the use of my personal information for the purposes described above)	◌ DATE (MM/DD/YYYY)
PATIENT SIGNATURE	

PAP FINANCIAL INFORMATION (For PAP eligibility determination only):

INITIALS REQUIRED ☐ I want LIVTENCITY Patient Assistance Program ("PAP") to conduct e-income verification which will include a soft credit check to determine household income. I understand that I am hereby providing "written instructions," under the Fair Credit Reporting Act (FCRA), authorizing the PAP and its vendors to run a soft credit check or other information about me from (the vendor) for the purpose of determining my financial eligibility for the PAP. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process for the PAP. I also understand that I may need to provide additional documentation and that additional eligibility requirements apply for the PAP.

- OR -

INITIALS REQUIRED ☐ Most recent income documentation attached (IRS form 1040, 1099, W-2 Form, etc).

I DECLARE AND AFFIRM THAT:

1. The information provided by me on this enrollment form is true and accurate;
2. I give consent to the PAP to disclose my enrollment in the PAP as needed to comply with legal and regulatory obligations;
3. I agree to notify the PAP immediately, in writing, if my prescription drug coverage changes in any way;
4. I will not seek or accept reimbursement from any health or prescription coverage plan, including a Medicare plan, for medication received from the PAP;
5. I understand that if I am eligible or enrolled in a Medicare plan, I will
- **a)** receive the requested medication from the PAP for the remainder of the enrollment calendar year for which my application was approved, and I will not seek the requested medication from my Medicare plan for the remainder of the enrollment calendar year;
- **b)** not seek true out-of-pocket (TrOOP) credit for any medication received from the PAP because I understand that medication received from the PAP will not count toward my TrOOP; and
- **c)** agree to notify my Medicare plan that I will receive my Takeda medication for free until the end of the year through the PAP;

6. I understand the product will be shipped to the home site on my behalf.

TEXT MESSAGING AGREEMENT TERMS & CONDITIONS

INITIALS REQUIRED ☐ 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 Terms & 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.

CONSENT FOR MARKETING COMMUNICATIONS

INITIALS REQUIRED ☐ 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.