Fax pages 2-6 to **866-467-7740** | Phone: **888-229-8379**

## Instructions for Completion of Form

- Complete sections 1-8 and **FAX PAGES 2-6 to 866-467-7740** and attach a copy of the patient's insurance card (front and back)
- Do not submit to Takeda any documentation of labs, clinical history, or other documents supporting the prior authorization process

### 1 Patient Information

### 2 Insurance Information

### 3 Prescriber Information

### 4 ADZYNMA Prescription Information and Prescribing Physician Signature

- Please indicate the number of refills
- This is a prescription; a physician's signature and date are required

**Rx: ADZYNMA [ADAMTS13, recombinant-krhn] (Enzyme Replacement Therapy for Prophylaxis)**

**Patient Name** (First Name and Last Name): _____ **DOB (MM/DD/YYYY):** _____

*Administer 40 IU/kg body weight of ADZYNMA once every other week or once weekly based on prior prophylactic dosing regimen or clinical response.*

☐ **Diagnosis (ICD-10): M31.19**

☐ **NKDA (No Known Drug Allergies)**

**Patient Body Weight (Kg):** _____ **X** **40 (IU):** _____ **Total Dose (IU):** _____ **-every-** **Week(s):** _____

| *Rx Product | *QTY | *No. of Refills |
|---|---|---|
| ☐ ADZYNMA 500 nominal IU vials | | |
| ☐ ADZYNMA 1500 nominal IU vials | | |

**Preferred infusion site:** ☐ **Infusion suite** ☐ **Hospital Outpatient** ☐ **Prescriber office** **If different please specify:** _____

☐ **Triage to Specialty Pharmacy (When Needed)**

**Prescriber Attestation Statement:**

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

**Prescriber Signature:** _____ **Date:** _____

### 5 Site of Care Information

### 6 Patient HIPAA Authorization

The patient signature is required to allow personal health information to be shared by third parties to Takeda to facilitate access to ADZYNMA (insurance benefits, transfer RX to specialty pharmacy provider, etc).

### 7 Patient Support Enrollment

### 8 Text Messaging Agreement Terms & Conditions

**Please see Important Safety Information on page 7 and click for Full Prescribing Information**

## 1. Patient Information

*Patient Name (first, middle, last): _____ *Gender†: ☐ M ☐ F

†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.

*Date of Birth (MM/DD/YYYY): _____ Age (Years): _____

*Street Address: _____

*City: _____ *State: _____ *ZIP: _____ Email: _____

*Primary Phone: _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

*Patient Preferred Language: _____ *Patient Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

Legal Representative Name (if applicable): _____

Legal Representative Primary Phone: _____ ☐ Home ☐ Work ☐ Cell

Legal Representative Email: _____

Relationship to Patient: _____

## 2. Insurance Information

Please attach copies of both sides of patient's medical and prescription insurance cards.

☐ Check here if the patient doesn't have Insurance

*Primary Insurance: _____ *Insurance Phone #: _____

*Subscriber (First, Last): _____ *Policy ID #: _____ *Group #: _____

*Pharmacy Plan Name: _____ *Pharmacy Plan Phone #: _____

*Rx ID #: _____ *Rx Group #: _____ *Rx BIN #: _____ *Rx PCN #: _____

Medicare Part D Plan: ☐ Yes ☐ No Insurance Phone #: _____

Subscriber (First, Last): _____ Policy ID #: _____ Group #: _____

Secondary Insurance: _____ Insurance Phone #: _____

Subscriber (First, Last): _____ Policy ID#: _____ Group #: _____

## 3. Prescriber Physician Information

*Prescriber Name (First, Last): _____

Tax ID #: _____ *NPI #: _____ PTAN: _____

*Facility Name: _____

*Facility Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone: _____ *Fax: _____ Email: _____

*Required Fields LEGAL NAME (first, middle, last)* _____ Date (MM/DD/YYYY) _____

## 4. ADZYNMA Prescription Information and Prescribing Physician Signature

**Rx: ADZYNMA [ADAMTS13, recombinant-krhn] (Enzyme Replacement Therapy for Prophylaxis)**

**Patient Name** (First Name and Last Name): _____ **DOB (MM/DD/YYYY):** _____

*Administer 40 IU/kg body weight of ADZYNMA once every other week or once weekly based on prior prophylactic dosing regimen or clinical response.*

☐ **Diagnosis (ICD-10): M31.19**

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**Patient Body Weight (Kg):** _____ **X** **40 (IU):** _____ **Total Dose (IU):** _____ **-every-** **Week(s):** _____

| *Rx Product | *QTY | *No. of Refills |
|---|---|---|
| ☐ ADZYNMA 500 nominal IU vials | | |
| ☐ ADZYNMA 1500 nominal IU vials | | |

**Preferred infusion site:** ☐ **Infusion suite** ☐ **Hospital Outpatient** ☐ **Prescriber office** **If different please specify:** _____

☐ **Triage to Specialty Pharmacy (When Needed)**

**Prescriber Attestation Statement:**

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

**Prescriber Signature:** _____ **Date:** _____

The prescriber is required to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in delay.

## 5. Site of Care Information (required if different from prescriber, if applicable)

*Practice/Facility Name: _____

*Practice/Facility Address: _____

*City: _____ *State: _____ *ZIP: _____

Treating Physician (if applicable): _____

Tax ID #: _____ *NPI #: _____

*Preferred Contact Name (first, last): _____

*Phone: _____ *Fax: _____ *Email: _____

*Required Fields LEGAL NAME (first, middle, last)* _____ Date (MM/DD/YYYY) _____

## 6. Patient HIPAA Authorization

By signing the Patient Authorization section of this Form, 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 ("Protected Health Information"), to Takeda Pharmaceuticals U.S.A., Inc. and its present or future affiliates, including the affiliates and service providers that work on Takeda's behalf in connection with the Hematology Support Center Patient Support Program (the "Companies"). The Companies will use my Protected Health Information for the purpose of facilitating the provision of the Hematology Support Center 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 support, financial assistance with co-pays, patient assistance programs, 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 the Hematology Support Center Patient Support Program and contact me, and/or the person legally authorized to sign on my behalf, about the Hematology Support Center Patient Support Program; 2) provide me, and/or the person legally authorized to sign on my behalf, with educational materials, information, and services related to the Hematology Support Center Patient Support Program; 3) verify, investigate, and provide information about my coverage for ADZYNMA, 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 Hematology Support Center 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. for marketing services. I understand that Protected Health Information disclosed under this Authorization 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 revoke this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Notice available at www.takeda.com/privacy-notice/ or I may revoke this Authorization at any time by sending written notice of revocation to the Hematology Support Center, PO Box 30831, Bethesda, MD 20824. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire at the earliest of what is required by state law, and never in any case longer than 5 years. I also understand that if I do not sign this Authorization, I will not be able to receive the Hematology Support Center Patient Support Program products, supplies, or services.

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

*Signature of Patient: _____ *Date (MM/DD/YYYY): _____

*Legal Representative Name: _____ *Relationship to Patient: _____

*Legal Representative Signature: _____ *Date (MM/DD/YYYY): _____

*Required Fields LEGAL NAME (first, middle, last)* _____ Date (MM/DD/YYYY) _____

## 7. Hematology Support Center Enrollment

By signing below, I am electing to enroll in Hematology Support Center 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 copays, 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).

**Hematology Support Center Enrollment: (I have read, understand, and agree to the release of my protected health information as described above)**

*Signature of Patient (Required): _____ *Date (MM/DD/YYYY): _____

*Legal Representative Name: _____ *Relationship to Patient: _____

*Legal Representative Signature: _____ *Date (MM/DD/YYYY): _____

### OPTIONAL:

☐ **Consent for Marketing Information** By checking the 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.

*Required Fields LEGAL NAME (first, middle, last)* _____ Date (MM/DD/YYYY) _____

## 8. Text Messaging Agreement Terms & Conditions

By agreeing to these Hematology Support Center (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. You can unsubscribe from receiving text messages by texting STOP. You will remain enrolled in the Hematology Support Center. For questions about this Program, text HELP or contact the customer support center at 888-229-8379.

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 into 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 888-229-8379.

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, as well as 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 U.S. carriers, including Verizon Wireless, Sprint, Nextel, Boost Mobile, T-Mobile®, AT&T, Alltel, ACS Wireless, Bluegrass Cellular, Carolina West Wireless, CellCom, Cellular One of East Central Illinois (ECIT), Cincinnati Bell, Cricket, C-Spire Wireless, Duet IP (aka Max/Benton/Albany), Element Mobile, Epic Touch, GCI Communications, Golden State, Hawkeye (Chat Mobility), Hawkeye (NW Missouri Cellular), Illinois Valley Cellular (IVC), Inland Cellular, iWireless, Keystone Wireless (Immis/PC Management), MetroPCS, MobiPCS, Mosaic, MTPCS/Cellular One (Cellone Nation), Nex-Tech Wireless, nTelos, Panhandle Telecommunications, Pioneer, Plateau, Revol Wireless, Rina-Custer, Rina-All West, Rina-Cambridge Telecom Coop, Rina-Eagle Valley Comm, Rina-Farmers Mutual Telephone Co, Rina-Nucla Nutria Telephone Co, Rina-Silver Star, Rina-South Central Comm, Rina-Syringa, Rina-UBET, Rina-Manti, Simmetry, South Canaan/CellularOne of NEPA, Thumb Cellular, Union Wireless, United Wireless, U.S. Cellular, Viaero Wireless, Virgin Mobile, and West Central Wireless (includes Five Start Wireless). By agreeing to these Hematology Support Center (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. You can unsubscribe from receiving text messages by texting STOP. You will remain enrolled in the Hematology Support Center. For questions about this Program, text HELP or contact the customer support center at 888-229-8379.

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.

**Text Communication Enrollment: (I have read, understand, and agree to opt-in for text communications as described above)**

Signature of Patient: _____ Date: _____

Legal Representative Name: _____ Relationship to Patient: _____

Legal Representative Signature: _____ Date: _____

Takeda

**What is ADZYNMA?**
ADZYNMA (ADAMTS13, recombinant-krhn) is a prescription medicine used to prevent or treat blood clots in patients with congenital thrombotic thrombocytopenic purpura (cTTP). This medicine replaces low amounts of the enzyme (ADAMTS13) in the body.

## Important Safety Information

**Do not take ADZYNMA** if you have had a life-threatening allergic reaction to ADZYNMA, or any of the ingredients in ADZYNMA.

**You can have an allergic reaction to ADZYNMA.** Call your healthcare provider right away and stop treatment if you get a rash or hives, itching, tightness of the throat, chest pain or tightness, difficulty breathing, lightheadedness, dizziness, nausea or fainting. Tell your healthcare provider if you have any allergies, including allergies to hamsters.

**The most common side effects** that have been reported with ADZYNMA include: are headache, diarrhea, migraine, abdominal pain, nausea, upper respiratory tract infection, dizziness and vomiting. These are not all of the possible side effects of ADZYNMA. For more information, ask your healthcare provider or pharmacist. You may report side effects to FDA at 1-800-FDA-1088.

**Your body can form inhibitors to ADAMTS13.** If you form inhibitors, they may stop ADZYNMA from working properly. Your healthcare provider may perform blood tests to monitor for the development of inhibitors to ADAMTS13.

**Talk to your healthcare provider** about the risk of taking ADZYNMA if you are pregnant, plan to be pregnant, are breastfeeding, or plan to breastfeed. It is not known if ADZYNMA will harm your unborn baby or if ADZYNMA passes into breast milk. Tell your healthcare provider about all the medicines you take, including prescription medicines and over-the-counter medicines, vitamins, and herbal supplements.

**To report SUSPECTED ADVERSE REACTIONS, contact Takeda Pharmaceuticals U.S.A, Inc. at 1-877-TAKEDA-7 (1-877-825-3327) or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.**

**Please see full Prescribing Information, including information for patients.**

Takeda