





Patient Assistance Within Reach

HOW DO I APPLY?

1. Patients

Complete Sections 1, 2 and 3. You must sign Section 3.

- If you have no income, initial the Income Attestation in Section 2 and discuss this with your healthcare provider.
- Complete Section 4 if you are enrolled in Medicare Part D, or Section 5 if you are eligible but not enrolled in Medicare Part D.
- Attach a copy of the Social Security Low Income Subsidy (LIS) denial letter, if applicable. Applicants will be referred to LIS when income is less than 135% of Federal Poverty Level (FPL) guidelines.

For further information, applicants can refer to www.socialsecurity.gov or may call 1-800-772-1213 (TTY 1-800-325-0778).

VERY IMPORTANT: Attach copies of your financial documentation from last year. *See Section 2 for details.* Do not send originals, as they cannot be returned.

2. Healthcare Provider

Complete Sections 6 and 7, and fax the signed application with all your documentation to 1-800-497-0928 or mail it to the address above.

Make sure to complete the patient name and date of birth at the top of page 4.

Takeda Patient Assistance Program

P.O. Box 5727, Louisville, Kentucky 40255-0727 Phone: 1-800-830-9159 Fax: 1-800-497-0928

CAN I APPLY?

You are eligible to apply for the Takeda Patient Assistance Program if:

- **1.** You are a legal resident of the United States.
- 2. You do not have prescription coverage through private or government programs. (If you are eligible for or enrolled in Medicare Part D, you may still apply — see Sections 4 and 5 for guidelines.)
- 3. You can provide your household's proof of income and are able to pay a reduced copayment (if applicable).
 See Payment Calculator and Payment Method on page 3.

IMPORTANT: Please go to next page. Call 1-800-830-9159 if you need help.

Patient Assistance Program representatives are available Monday through Friday, 8:30 a.m. to 6:00 p.m. ET. Incomplete applications, missing information or documents, or neglecting to include your required payment (if there is one) will delay the processing of your application.

Medication (generic)

This is the application you should use if you have a prescription for these products:

COLCRYS (colchicine, USP)

ULORIC (febuxostat)

Takeda Patient Assistance Program

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK



	SECTION 1: PATIENT	INFORMATIO	N		
First Name	ame Last Name		Home Address		
City	State	ZIP Code		Preferred Daytime Phone Number	
Social Security Number (or Green C	ard or Visa Number)	☐ MALE ☐ FEM	IALE	Date of Birth (MM/DD/YYYY)	
U.S. Resident YES NO	U.S. Veteran YES NO		_	will be to patient unless otherwise indicated. E PROVIDER	
	SECTION 2: INSURAN	ICE AND INCOM	ΜE		
Do you have prescription drug covera	ge? Yes (check all that apply) No	Number of people			
_	Medicare Part D*	Total <i>yearly</i> househ	nold income	e: \$	
	/A benefits	Have you received for at least two ye		curity Disability Income YES NO	
IMPORTANT: Do you have a copy of	last year's federal income tax return?	YES NO			
If you marked YES, you must include a return(s) for yourself, your spouse as has changed significantly, or if you a income statement or proof of unem	If you marked NO, you must do one of the following: Provide a signed IRS Form 4506-T, or Provide a copy of Social Security Benefits Statement, or Provide copies of all income statements from jobs held last year, or Initial the Attestation of "No Income" below				
	INCOME ATTE		Station of	No meome below	
My family has zero income and therefore I will not be able to submit proof of income. (Initial this box only if the family has zero income.)					
*Complete Section 4 if enrolled in a Medicare Part D plan *Complete Section 5 if eligible, but not enrolled in a Medicare Part D plan					
SECTION	3: PATIENT HIPAA AUTHO	RIZATION ANI	CERTI	FICATION	
PLEASE R	EAD THE FOLLOWING STATEM	ENT CAREFULLY A	ND SIGN	I BELOW	
ceuticals America, Inc. (Takeda) and Assistance Program (Program), all pe	re provider (listed in Section 6) and m its affiliated companies, or third-party ersonal information relating to my me ster my participation in the Program.	contractors assisting	Takeda in	connection with the Takeda Patient	
I may refuse to sign this authorization. If I refuse, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment, or affect my insurance enrollment or eligibility for insurance benefits. I may cancel this authorization at any time by mailing a letter of cancellation to Takeda at the address listed at the top of this application form. If I cancel this authorization, I will no longer be allowed to participate in the Program. Cancelling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed by Takeda, but will not affect disclosures made before that time.					
I understand that once my personal information is disclosed to Takeda or its contractors, federal privacy laws may no longer protect the information from further disclosure. However, my personal information will not be used or disclosed by Takeda or its contractors for any purpose other than to determine my eligibility and to administer my participation in the Program. This authorization expires at the end of my participation in the Program.					
I certify that the information on this form is accurate and complete to the best of my knowledge. I agree that Takeda and its contractors may also contact my health insurer to verify my insurance information.			Takeda and its contractors may also		
Patient Signature (Stamped Signature X	es NOT ALLOWED)		Date		

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Patient Name:	DOB:
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PAYMENT CALCULATOR AND PAYMENT METHOD

Select your household size from the first column. Household size equals you, your spouse, and your dependents. Go across the row until you find your household income level. If your income is more than the income listed in the last column, you may not qualify at this time.

Household size	30-day supply is free if yearly income is less than:	30-day supply reduced price of \$5 if yearly income is":	30-day supply reduced price of \$25 if yearly income is	You may not qualify if yearly income is more than:
1	\$33,510	\$33,511–\$ 44,680	\$44,681–\$67,020	\$67,020
2	\$45,390	\$45,391–\$ 60,520	\$60,521–\$90,780	\$90,780
3	\$57,270	\$57,271–\$ 76,360	\$76,361–\$114,540	\$114,540
4	\$69,150	\$69,151–\$ 92,200	\$92,201–\$138,300	\$138,300
5	\$81,030	\$81,031–\$108,040	\$108,041-\$162,060	\$162,060

^{*60-}day and 90-day supplies are also available at no cost **60-day supply payment is \$10, 90-day supply payment is \$15 ***60-day supply payment is \$50, 90-day supply payment is \$75

If you are not required to make a payment, leave this section blank. If you anticipate qualifying for a reduced price, complete the following:			
☐ Credit card ☐ Enclose check or	oney order payable to AmeriCares		
Name as it appears on credit card	Expiration Date: Month Year		
Billing Address (If different from your address on page one)	Security Code (on back of card)		
	Card Type: ☐ VISA ☐ MasterCard ☐ Discover ☐ Ar	merican Express	
Amount Paid	Card Number		
Cardholder Signature	Date		
X			
SECTION 4: COMPLETE ONLY IF YO	ARE ENROLLED IN MEDICARE PART D		
1. I understand that if approved for assistance, I will be able to receiv (Program) for the remainder of the enrollment calendar year* for		stance Program	
2. I will not seek the requested medication from my Medicare Part [lan for the remainder of the enrollment calendar year. st		
3. I will not seek or accept reimbursement from my Medicare Part D	an for medication received from the Program.		
4. I will not seek true out-of-pocket (TrOOP) credit for any medication received from the Program will not count toward my TrOOP.	received from the Program because I understand that n	nedication	
5. I give consent to the Program to disclose my enrollment in the Pr	ram as needed to comply with legal and regulatory obli	igations.	
6. I agree to notify the Program immediately, in writing, if my presc	tion drug coverage changes in any way.		
*Enrollment calendar year is the calendar year for which this applica	n is being submitted.		
Patient Signature	Medicare ID# (required) Date		

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- ${\tt 1.Ideclare\ and\ affirm\ that\ I\ am\ eligible\ AND\ not\ currently\ enrolled\ in\ a\ Medicare\ Part\ D\ Plan.}$
- 2. I give consent to the Program to disclose my enrollment in the Program as needed to comply with legal and regulatory obligations.

3. I agree to notify the Program immediately, in writing, if my prescription drug coverage changes in any way.		
Patient Signature X	Date	

Takeda Patient Assistance Program

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atient Name:		DOB:		_	
	SECTION 6: HEALT	HCARE PROVIDER I	NFORMATION		
ast Name	First Name	Clinic Name (if a	applicable)		
Address		City		State	ZIP Code
State License Number		Phone	Fax		
ist all current patient med	ications below:	'	ic to any medications ist below) NO	?	
SECTION 7: PRESC	RIPTION INFORMATION	ON (NJ and NY physicia	ans please attach a	ppropriate	prescription)
MEDICATION		RECTIONS	QUANTITY	DAYS SUPPL	
				day	S
				day	'S
his application, and not be r	the product is sent to my office esold or offered for sale or trade, to the best of my knowledge, th	nor shall the patient nor any	y third-party payer, Me		
	e (Stamped Signatures NOT ACCE	PTED)		Date	

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Have your healthcare provider's office fax to: 1-800-497-0928

Mail your complete application and other papers to: TAKEDA PATIENT ASSISTANCE PROGRAM P.O. Box 5727, Louisville, Kentucky 40255-0727

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