Takeda Pharmaceuticals America, Inc.

PATIENT ASSISTANCE PROGRAM
PO Box 181700
Louisville, KY 40261-1700

INSTRUCTIONS

The Takeda Pharmaceuticals America, Inc. Patient Assistance Program ("the Program") provides Prevacid (lansoprazole) capsules or Prevacid SoluTab (lansoprazole) orally disintegrating tablets at no charge to qualified patients in need. The need of a patient is determined according to guidelines established by Takeda Pharmaceuticals America, Inc. that are based on federal standards. The Patient Assistance Program may be changed or discontinued at any time at the sole discretion of Takeda Pharmaceuticals America, Inc.

Enrollment Process: Call 1-800-830-1015 to obtain an application for the Patient Assistance Program for Prevacid or Prevacid SoluTab. An application will be promptly faxed to the physician's office or mailed to the patient.

Please complete all applicable sections. If an item does not apply, please mark N/A on the line. Incomplete applications will not be processed.

Section 1 – Physician Information
This section must have all physician information completed and signature of the physician is required. An original prescription must be included with the application.

Section 2 – Patient Information
This section must have all patient information completed. Patient must list all medications he or she is currently taking and list any allergies.

Section 3 – Patient Insurance Information
All questions must be answered to determine patient eligibility. If a patient replies yes to Medicare Part D, Section 6 must be completed and signed. If a patient replies "no" to Medicare Part D, Section 7 must be completed and signed.

Section 4 – Household Financial Information
Patients must list all sources of income. To assess a patient's need, **financial documentation is required.** Applications submitted without the proper financial documentation will not be processed and will be returned to the patient with a letter specifying the information that is missing. Acceptable documentation means the patient's most recent federal income tax return. If the patient did not file a federal income tax return in the last sixteen (16) months, then please submit each of the following that applies to the patient:

- Yearly Benefits Statement (SSA-1099)
- IRS Form 4506T (Request for Transcript of Tax Return/ Verification of Nonfiling)*
- IRS Telefile Worksheet
- W2 Tax Statement
- Social Security, Pension, or Railroad Retirement statements (SSA-1099)
- Statements of Interest, Dividends or Other Income (1099-INT, 1099, 1099T, 1099-DIV)

*Patients can get a copy of the IRS Form 4506T by calling a Customer Service Representative at 1-800-830-1015.

Section 5 – Patient Signature (Required)
Patient's signature is required for eligibility determination.

Section 6 – Medicare Part D Prescription Drug Plan Contact Information
This section must be completed by a patient who is currently enrolled in a Medicare Part D Prescription Drug Plan and is not receiving his or her requested medication from the plan. All sections must be completed, and the patient's signature is required. If patient meets all Takeda eligibility criteria, he/she will be enrolled for the remainder of the current calendar year.

Part D enrollees may not receive medication beyond the end of that calendar year without reapplying and being approved for the subsequent calendar year. The patient may reapply for the next calendar year by following the same enrollment process described above. Eligibility will be determined based on the updated information provided.

Section 7 – Affirmation of Non-Enrollment in Medicare Part D Plan
This section must be completed by any applicant or re-enrollee who is eligible for Medicare Part D but is not currently enrolled in a Medicare Part D plan OR does not qualify for Medicare and is 65 years or older. Patient signature is required.

A patient who is not enrolled in Part D may receive medication for up to one year. To receive medication from the Program beyond one year, the patient must reapply on an annual basis. Eligibility will be determined based on the updated information provided at the time of reapplication.

Submission of Application, Approval and Shipment of Medication: Once the enrollment application is complete, physicians may fax the application, financial documentation, and an original prescription to 1-800-394-2794 or patient can mail all documents to the address indicated above. A Takeda Program specialist will evaluate the application using the pre-established program guidelines to determine the patient's eligibility. If the patient is approved for participation in the Program, an approval letter will be mailed to the patient and physician confirming the patient's acceptance into the Program and a 90- to 100-day supply of Prevacid or Prevacid SoluTab will be shipped to the patient's home (unless otherwise specified) within 4 – 5 business days. If an application is denied, a denial letter will be mailed to the patient and to the physician.

Continued Assistance/Refill Process: If refills are available, the patient or physician may reorder by calling 1-800-830-1015. Refill mailers will be provided with each shipment. Refill mailers may be completed with a prescription enclosed and mailed to the address indicated on the mailer.

Takeda

Takeda Pharmaceuticals America, Inc.

Patient Assistance Program

1-800-830-1015 Phone
1-800-394-2794 Fax

AVAILABLE MEDICATION:

- PREVACID Capsules (lansoprazole) 15 mg and 30 mg
- PREVACID SoluTab (lansoprazole) orally disintegrating tablets 15 mg and 30 mg

Please attach an original prescription.

SECTION 1 PHYSICIAN INFORMATION

Physician Name		DEA/State License #
Address	City, State & Zip Code	
Office Phone Number (	Office Fax Number (	Office Contact person

I certify that I will dispense the medication only for the use by the patient designated below, that the product ordered hereunder is medically indicated for the patient, and that I will be supervising the patient's treatment. Neither the patient nor any third party payer, (including, but not limited to, Medicare, Medicaid, or any other federally funded healthcare program) was or will be charged for this product. Additionally, I understand this medication cannot be sold, offered for sale or trade, or returned for credit. I understand that eligibility for this Program is subject to Takeda's approval and the patient's continuing compliance with all eligibility requirements as established by Takeda. I agree to allow Takeda, or its authorized agent(s), to review the medical, financial, and insurance records for this patient at any time for the purpose of verifying the patient's eligibility for the program and the patient's receipt of any product provided to him or her under the program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-named patient.

Physician's signature **(Required)** **X**	Date

SECTION 2 PATIENT INFORMATION

Name		SSN/ID Number	Date of Birth
Address		City, State & Zip Code	
Daytime Phone	Legal US Resident ◯ Yes ◯ No	Number of people in household (including self): (Circle One) 1 2 3 4 5 6	
List any patient allergies			
List any other medications			

SECTION 3 PATIENT INSURANCE INFORMATION

Do you have Prescription Drug Coverage?	**Are you enrolled in Medicare Part D?**	**Are you enrolled in Medicaid?**
◯ Yes ◯ No	◯ Yes* ◯ No* *If yes, see section 6, If no, see section 7	◯ Yes ◯ No

SECTION 4 HOUSEHOLD FINANCIAL INFORMATION

You must list all sources of Total Monthly Household Income and attach a copy of your most recent U.S. income tax return (i.e., IRS Form 1040, 1040A, 1040EZ, 4506T, and 1099). **If you did not file an income tax return, you may complete and submit an IRS form 4506T (Request for Transcript of Tax Return/Verification of Nonfiling).** Total Monthly Household Income includes gross monthly income of patient, spouse and others living in household. You must include salary, pension, Social Security income, SSI-Supplemental Security income, Social Security Disability and Unemployment Compensation.

Salary/Wages	$_____	Social Security	$_____	Child Support/Alimony	$_____
Disability	$_____	Pension/ Retirement	$_____	Unemployment/ Work Comp	$_____

Gross Monthly Income **Total: $**_____

Notice to all parties completing this form: It is fraudulent to fill out this form with information under this program you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts. The Takeda Pharmaceuticals America, Inc. Patient Assistance Program for Prevacid or Prevacid SoluTab, as with all programs, can be discontinued or changed at any time without notice at the discretion of Takeda Pharmaceuticals America, Inc.

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SECTION 5 PATIENT SIGNATURE

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TAKEDA PHARMACEUTICALS AMERICA, INC. PATIENT ASSISTANCE PROGRAM ("PROGRAM")

I allow my health care providers, physicians, any specialty pharmacy or specialty distribution center, third party service provider, or my health plans (collectively, Providers), if any, to use, share, and disclose my protected health information (PHI) as requested by the Program. This PHI includes my name, information from my medical record, health plan information and financial information. My PHI will be given to Takeda Pharmaceuticals America, Inc. ("Takeda"), AmeriCares and any other contractors or partners that help with the Program. These uses and disclosures of my PHI are so that I may apply and, if approved, receive Prevacid or Prevacid SoluTab from the Takeda Program. My information will be treated confidentially to the extent required by law. I understand that if my PHI is disclosed, federal privacy laws may no longer protect the information from further disclosure. This authorization expires one (1) year from the date of my signature below. I can choose not to sign this form or cancel this authorization at anytime. If I want to cancel this authorization, I will be required to send a written request to Takeda. This cancellation will apply to Providers when my cancellation notice is received by those Providers. My cancellation will not apply to PHI already obtained by Providers if they have already used or disclosed my PHI, or acted in reliance on my authorization. I understand that by not signing this form my health care treatment outside the Takeda Program, health plans' payment for health care, or my ability to get benefits from health plans will not be affected. Signing this form is not a guarantee that I will be able to receive Prevacid or Prevacid SoluTab from the Takeda Program. I acknowledge that I have been provided a copy of this authorization.

My signature certifies that the information on this form is true and correct. I certify that (i) I do not have prescription drug coverage, with the possible exception of Medicare Part D coverage; (ii) I will notify the Takeda Program immediately in writing if I obtain prescription drug coverage; and (iii) I will not submit to any third-party payer a claim for any medication that may be provided to me by the Takeda Program. If I enroll in Medicare Part D, I certify that I will comply with all requirements listed in Section 6 of this application. I consent to the release by my Providers of my medical information pertaining to the Takeda Program to be used for program authorization purposes. I authorize Takeda and its agents and assignees to use the information on this application to process the request for medication from the Takeda Program and further authorize the use of my Social Security number for identification purposes and record keeping. I understand Takeda reserves the right at any time without notice to modify or discontinue this program and its eligibility criteria.

Patient or personal representative's signature **(Required)** **X**	Date
Personal Representative relationship to the Patient:	

SECTION 6 Medicare Part D Prescription Drug Plan Contact Information

This section must be completed by any applicant who has enrolled in a Medicare Part D Prescription Drug Plan.

1. I understand that if approved for assistance I will be able to receive the requested medication from the Takeda Pharmaceuticals America, Inc. Patient Assistance Program ("the Program") for the remainder of the enrollment calendar year for which my application was approved.
2. I agree that I will not seek the requested medication from my Medicare Part D plan for the remainder of the enrollment calendar year.
3. I agree that I will not seek or accept reimbursement from my Part D plan for any medication received from the Program.
4. I agree that I will not seek true out-of-pocket (TrOOP) credit for any medication received from the Program because I understand that medication received from the Program will not count toward my TrOOP.
5. I give consent for the Program to disclose my enrollment in the Program to my Medicare Part D plan.
6. I agree to notify the Program immediately in writing if my prescription drug coverage changes in any way.
7. I understand that any assistance provided through the Program is temporary and that the Takeda Program can be changed or discontinued at any time at the sole discretion of Takeda Pharmaceuticals America, Inc.

Enrollment Calendar Year means the calendar year for which this application is being submitted.
Enrollment in the program is being requested for the following calendar year:

Prescription Drug Plan Name		
Prescription Drug Plan Phone Number		
Prescription Drug Plan Address		
City	State	Zip
Patient Signature		Date

SECTION 7 Affirmation of Non-Enrollment in Medicare Part D Plan

This section must be completed by any new applicant or re-enrollee who is eligible for Medicare Part D but is not currently enrolled in a Medicare Part D plan OR does not qualify for Medicare and is 65 years or older.

1. I declare and affirm that I am not currently enrolled in a Medicare Part D plan OR I am 65 years or older and do not qualify for Medicare.
2. I agree to notify the Program in writing immediately if my prescription drug coverage changes in any way or if I enroll in a Medicare Part D plan.
3. I understand that any assistance provided through the Program is temporary and that the Program can be changed or discontinued at any time at the sole discretion of Takeda Pharmaceuticals America, Inc.

Patient Signature	Date

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