Daryl
Takeda Oncology
Here2Assist patient

Takeda Oncology Here2Assist

ICLUSIG® (ponatinib)
RapidStart Request Form

How the RapidStart Program* helps

If your patient experiences a delay in insurance coverage determination of at least 5 days, they may be eligible to receive a 1-month supply of medication at no cost to them.

Patients must have a completed Takeda Oncology Here2Assist™ Enrollment Form on file to apply for the RapidStart Program. Terms and Conditions apply.*†

How to enroll in the RapidStart Program

1. **COMPLETE ALL INFORMATION** on page 3 in its entirety with your patient, including prescriber information, patient information, shipping information, treatment history, statement of medical necessity, prescription request, and authorization.

2. **SIGN AND DATE** the form. Prescriber and patient (or legal representative) authorization is required in the form of an original signature following review of the prescriber authorization and the patient authorization sections.

   IMPORTANT: Original signatures are required.
   Please ensure original signatures for the prescriber and patient (or legal representative) are applied. Stamped signatures will not be accepted. Applications that do not include original signatures cannot be processed, and your patient's enrollment may be delayed.

3. **FAX** the completed and signed form to Takeda Oncology Here2Assist at 1-844-269-3038.

   IMPORTANT: The RapidStart Request Form is only valid if received by fax.

Please see ICLUSIG® full Prescribing Information, including Boxed Warning.

*The RapidStart Program provides a 1-month supply of treatment of the prescribed Takeda Oncology medication at no charge for eligible patients new to therapy experiencing a delay in insurance coverage determination of at least 5 business days. There is no purchase obligation by virtue of a patient's participation in the RapidStart Program. Patients must have an on-label, valid prescription for the Takeda Oncology medication and a medical necessity for being prescribed the Takeda Oncology medication. Patients must be enrolled in the Takeda Oncology Here2Assist Program to qualify. Free product for the RapidStart Program will only be available through the RapidStart Program noncommercial specialty pharmacy. A delay in coverage determination of at least 5 days is required for patients to be eligible for the RapidStart Program. The program may not be combined with any other offer and is not available to patients whose insurers have made a final determination to deny the patient coverage for the prescribed Takeda Oncology medication. Takeda reserves the right to change or end the program at any time. Benefits provided under the program are not transferable.

†Separate program enrollment is required for the Takeda Oncology Here2Assist Program.

For more information, call us at 1-844-817-6468, Option 2, or visit www.Here2Assist.com. **Let's Talk.** We're available Monday-Friday, 8AM-8PM ET.

Takeda Oncology Here2Assist

ICLUSIG® (ponatinib) RapidStart Request Form

Fax to 1-844-269-3038 or **call** 1-844-817-6468, Option 2, Monday-Friday, 8AM-8PM ET

Complete this additional ICLUSIG® (ponatinib) RapidStart Request Form for insured patients who are receiving their first prescription of ICLUSIG and are experiencing a delay in insurance coverage determination. The ICLUSIG RapidStart Program* may provide eligible patients with a 1-month supply of ICLUSIG at no cost to them. Terms and Conditions apply.*

Please see ICLUSIG® full Prescribing Information, including Boxed Warning.

PRESCRIBER INFORMATION

Name (First, Middle, Last): Practice Name:

Address: City: State: ZIP:

Phone: Fax: Primary Office Contact:

State License #: NPI: Medicare/Medicaid Provider #: Reimbursement Contact:

PATIENT INFORMATION

Name (First, Middle, Last): Date of Birth (MM/DD/YYYY): Gender: ❑ Male ❑ Female

Address: City: State: ZIP:

Phone: OK to leave message? ❑ Yes ❑ No Email:

Mobile: OK to leave message? ❑ Yes ❑ No

SHIPPING INFORMATION

Ship to patient's home address indicated above? ❑ Yes ❑ No. Ship to address below

Patient Name: Contact Person Name: Phone:

Address: City: State: ZIP:

IMPORTANT: Product cannot be shipped to a PO Box.

TREATMENT HISTORY

Previous therapies, if any:

STATEMENT OF MEDICAL NECESSITY

ICD-10 Code:

PRESCRIPTION REQUEST: To permit medication to be sent to your patient, the prescription information must be complete and accurate.

*The RapidStart Program provides a 1-month supply of treatment of the prescribed Takeda Oncology medication at no charge for eligible patients new to therapy experiencing a delay in insurance coverage determination of at least 5 business days. There is no purchase obligation by virtue of a patient's participation in the RapidStart Program. Patients must have an on-label, valid prescription for the Takeda Oncology medication, and a medical necessity for being prescribed the Takeda Oncology medication. Patients must be enrolled in the Takeda Oncology Here2Assist™ Program to qualify. Free product for the RapidStart Program will only be available through the RapidStart Program noncommercial specialty pharmacy. A delay in coverage determination of at least 5 days is required for patients to be eligible for the RapidStart Program. The program may not be combined with any other offer and is not available to patients whose insurers have made a final determination to deny the patient coverage for the prescribed Takeda Oncology medication. Takeda reserves the right to change or end the program at any time. Benefits provided under the program are not transferable.

PRODUCT	DOSAGE	DIRECTIONS	DISPENSE
ICLUSIG® (ponatinib)	mg		30-day supply

PROVIDER AND PATIENT AUTHORIZATIONS

By signing below, I certify that ICLUSIG is being prescribed for an on-label diagnosis, the patient is new to ICLUSIG treatment, and the prescription complies with all applicable local and state laws. I have read and understand the RapidStart Program Terms and Conditions, and I agree that I shall not seek reimbursement for any ICLUSIG dispensed to the patient through the RapidStart Program from any government program or third-party insurer. I further certify that I will not attempt to sell, barter, or return for credit any ICLUSIG provided under this program. I understand that I am under no obligation to prescribe or purchase ICLUSIG or any other product manufactured by Takeda, and I certify I have received nothing of value from Takeda or its agents or representatives for prescribing a Takeda product.

SIGN HERE **Prescriber Signature:** (no stamp allowed) _____ **Date:**

ATTENTION New York State Prescribers: Prescribers in New York State must submit the prescription on an original New York State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank if applicable for your state.

By signing below and accepting the benefits of the program, I certify that I have not previously been prescribed ICLUSIG; and I will not seek reimbursement or credit from any insurer, healthcare plan, or government program; and will not sell or trade ICLUSIG provided under the program. If I am enrolled in a Medicare Part D plan, I certify that I will not attempt to have this prescription or any cost associated with it counted as any portion of my true out-of-pocket ("TrOOP") cost for prescription drugs calculations.

SIGN HERE **Patient Signature:** _____ **Date:**

Legal Representative Signature: _____ **Relationship:** **Date:**

Takeda ONCOLOGY