

ANNOTATED GUIDE

This guide can be used to help complete the **required components** of the Takeda Patient Support Start Form before faxing it to Takeda Patient Support. Submission of this form, which also serves as a prescription, is the first step to getting your patients started on treatment. If the form is incomplete, Takeda Patient Support will reach out to your office to collect the missing information, which may delay the onboarding process.

Please use a dark-colored pen when filling out the Start Form.

A PATIENT INFORMATION

Ensure the patient's full contact information is entered, including their email address and phone number. Takeda Patient Support will need to establish contact with your patient before TAKHZYRO can be shipped. **Tell your patient to save the Takeda Patient Support number 1-866-888-0660 on their phone to avoid spam blockers.**

B PATIENT CONSENT

Takeda requires a patient signature for 2 elections: **Patient Authorization and Takeda Patient Support Program and Communication Enrollment.** Patients should review the elections on page 3 (not shown) of the Start Form prior to signing.

C MARKETING COMMUNICATIONS

Your patient can choose to opt in to receive marketing communications, which include information about **upcoming patient events in their area** and other topics related to TAKHZYRO.

D DOSAGE

Before submitting this form to Takeda Patient Support, be sure to select only 1 box that corresponds to your patient's age and preferred dosing frequency (every 2 weeks or every 4 weeks).

E DIAGNOSIS

To begin therapy, a diagnosis is required. Check 1 of the 2 boxes in section 4.

F TRAINING

By submitting this form to Takeda Patient Support, your patient or their caregiver will automatically be signed up for administration training, and a Patient Support Manager will reach out to them for scheduling. *If you choose to opt your patient out of these services, you must check this box.*

G PRESCRIBER SIGNATURE

The prescriber's signature and the date are required before faxing this form to Takeda Patient Support.

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TAKEDA PATIENT SUPPORT START FORM

US-LANA-1612v3.0

Fax page 1 to 1-855-663-7284.
For assistance, call 1-866-888-0660.

1. Patient Information

US-LANA-1612v3.0
Fax page 1 to 1-855-663-7284.
 For assistance, call 1-866-888-0660.

Name (First, Middle Initial, Last) M F

Male/Female* MM/DD/YYYY

Email Address

Street Address City State ZIP Code

Primary Telephone to reach Patient Type Preferred time to call

DOB

MM/DD/YYYY

2. Insurance Information

Please attach copies of both sides of the patient's insurance card(s). Check this box if the patient does not have insurance.

Primary Insurance Insurance Telephone Policy ID #

Group ID # Policy Holder Name (First, Last) and Relationship to Patient

Policy Holder DOB: Month/Day/Year

Pharmacy Plan Name Pharmacy Plan Telephone

Policy ID # Group #

Rx BIN # Rx PCN #

Secondary Insurance Secondary Insurance Telephone

Secondary Policy ID # Secondary Group ID #

Policy Holder Name (First, Last) and Relationship to Patient Policy Holder DOB: Month/Day/Year

Patient Authorization

SIGN HERE

Patient Signature or Caregiver/Legal Representative Signature Date

I have read, understand, and agree to the release of my protected health information, as described on page 3, section 5 of this form.

Takeda Patient Support Program and Communication Enrollment

SIGN HERE

Patient Signature or Caregiver/Legal Representative Signature Date

I have read, understand, and agree to the use of my personal information for the purposes described on page 3, section 6 of this form.

I would like to opt in to marketing communications as described on page 3, section 7 of this form.

3. Prescribing Physician Information

Name (First, Last) Site Name Street Address City State

ZIP Code Office Contact Office Telephone Fax State License # National Provider ID #

4. TAKHZYRO Prescription, Administration, and Prescribing Physician Signature

DOSAGE (IMPORTANT—ONLY CHECK ONE BELOW):

DIAGNOSIS (SELECT ONE): ICD-10 D84.1 OR Other

≥12 YEARS OF AGE	6 TO <12 YEARS OF AGE	2 TO <6 YEARS OF AGE
<p>TAKHZYRO (lanadelumab-flyo) 150 mg/mL. One (1) single-dose pre-filled syringe 2 mL (47783-646-01)</p> <p>(FDA label recommended starting dosage)*</p> <p><input type="checkbox"/> One (1) dose (1 syringe [2 mL]=300 mg every two [2] weeks). Dispense quantity of 2 syringes; 4 weeks' supply</p> <p><input type="checkbox"/> One (1) dose (1 syringe [2 mL]=300 mg every four [4] weeks). Dispense quantity of 1 syringe; 4 weeks' supply</p>	<p>TAKHZYRO (lanadelumab-flyo) 150 mg/mL. One (1) single-dose pre-filled syringe 1 mL (47783-645-01)</p> <p>(FDA label recommended starting dosage)*</p> <p><input type="checkbox"/> One (1) dose (1 syringe [1 mL]=150 mg every two [2] weeks). Dispense quantity of 2 syringes; 4 weeks' supply</p> <p><input type="checkbox"/> One (1) dose (1 syringe [1 mL]=150 mg every four [4] weeks). Dispense quantity of 1 syringe; 4 weeks' supply</p>	<p>TAKHZYRO (lanadelumab-flyo) 150 mg/mL. One (1) single-dose pre-filled syringe 1 mL (47783-645-01)</p> <p><input type="checkbox"/> One (1) dose (1 syringe [1 mL]=150 mg every four [4] weeks). Dispense quantity of 1 syringe; 4 weeks' supply</p>
<p>DIRECTIONS: Administer or self-administer subcutaneous injection as prescribed by the physician in the dosage section.</p> <p>REFILLS: <input type="checkbox"/> 11 months OR <input type="checkbox"/> Other</p>		

INJECTION TRAINING: TAKHZYRO is intended for self-administration or administration by a caregiver. The patient or caregiver should be trained by a healthcare professional. Takeda Patient Support provides free injection training services to all TAKHZYRO patients unless you opt out below.

If you choose to **opt out** of these services, please check this box.

Prescriber Signature

SIGN HERE

(Stamps not acceptable) (Dispense as written)

PHYSICIAN CERTIFICATION: By signing this form, I certify that therapy with TAKHZYRO is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current TAKHZYRO 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 TAKHZYRO therapy to Takeda Pharmaceuticals U.S.A., Inc., including its agents or contractors, for the purpose of seeking information related to coverage and/or assisting in initiating or continuing TAKHZYRO 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, must not be resold, offered for sale or trade or returned for credit.

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