Takeda Oncology 1Point™ is a comprehensive support program committed to helping patients navigate coverage requirements, identify available financial assistance, and connect with helpful resources throughout their therapy. Patients who are prescribed ALUNBRIG® (brigatinib), ICLUSIG® (ponatinib), or NINLARO® (ixazomib) are eligible to enroll in this program.

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

For more information, call us at 1-844-T1POINT (1-844-817-6468), Option 2, or visit www.TakedaOncology1Point.com. Let’s Talk. We’re available Monday-Friday, 8AM-8PM ET.
How to enroll a patient in Takeda Oncology 1Point™

1. COMPLETE ALL INFORMATION in its entirety with your patient, including product selection, prescriber information, patient information, current insurance, treatment history, specialty pharmacy information, and prescription information.

2. SIGN AND DATE the form. Prescriber and patient (or patient 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 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 along with a copy of your patient’s insurance card and prescription to Takeda Oncology 1Point at 1-844-269-3038.

   IMPORTANT: Prescription is only valid if received by fax.

What to expect after enrollment

After your patient’s enrollment form is received and processed, a Takeda Oncology 1Point case manager will conduct a benefits verification to determine the patient’s prescription coverage and potential out-of-pocket costs. A summary of coverage will be provided to your office within 2 business days.*

Takeda Oncology 1Point offers additional support

For patients who experience a delay in coverage determination, are uninsured, or who have insurance but are not covered for the prescribed medication, Takeda Oncology 1Point offers additional support. Learn more about the Patient Assistance Program† and the RapidStart Program‡ at www.TakedaOncology1Point.com, or call 1-844-T1POINT (1-844-817-6468).

For more information, call us at 1-844-T1POINT (1-844-817-6468), Option 2, or visit www.TakedaOncology1Point.com. Let’s Talk. We’re available Monday-Friday, 8AM-8PM ET.

*Verification of benefits is not a guarantee of payment and does not take the place of written policy information. Terms and Conditions apply.
†Separate program enrollment is required. Terms and Conditions apply.
Product (select one) ALUNBRIG® (brigatinib) ICLUSIG® (ponatinib) NINLARO® (ixazomib)

Please see accompanying 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: ___________ Medicaid/Medicare 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: ________________

[ ] Yes [ ] No I give permission to Takeda to contact me by mail, email, phone, or SMS/text message for the purposes of communicating promotional content related to Takeda products and services. Automatic dialing may be used. Carrier, text, and data rates may apply.

I understand that I am not required to provide this consent as a condition of purchasing any goods or services.

Current Insurance Information

Please attach copies of both sides of the patient’s insurance card(s). Include both medical and pharmacy information if available.

Insurance Plan: [ ] Medicare [ ] Medicaid [ ] Private/Commercial [ ] Other: __________________________
Primary Insurer Name: ___________________________ Insurer Phone: ___________________________
Policy Holder Name (First, Middle, Last): ___________________________ Policy Holder Date of Birth (MM/DD/YYYY): ___________
Policy ID #: ___________ Group #: ___________ RX BIN #: ___________ RX PCN #: ___________
Secondary Insurer Name: ___________________________ Insurer Phone: ___________________________
Policy Holder Name (First, Middle, Last): ___________________________ Policy Holder Date of Birth (MM/DD/YYYY): ___________
Policy ID #: ___________ Group #: ___________ RX BIN #: ___________ RX PCN #: ___________

[ ] Patient has no insurance [ ] Patient’s insurance is pending with (include name of insurer here): ___________________________

Visit www.TakedaOncology1Point.com to learn how the RapidStart Program can help eligible patients experiencing a delay in insurance coverage determination.

Statement of Medical Necessity

ICD-10 Code: __________________________________________________________

Pharmacy Preference (select one)

[ ] Specialty Pharmacy Name: ___________________________ [ ] In-office dispensing [ ] No pharmacy preference
For a list of Takeda Oncology 1Point® network specialty pharmacies, visit www.TakedaOncology1Point.com

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

<table>
<thead>
<tr>
<th>PRODUCT (select one)</th>
<th>DOSAGE</th>
<th>DIRECTIONS</th>
<th>DISPENSE</th>
<th>REFILLS (please select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALUNBRIG® (brigatinib) tablets</td>
<td>90 mg orally once daily for 7 days; then 180 mg orally once daily for 23 days.</td>
<td>Fill out dosing instructions for subsequent brigatinib refills below.</td>
<td>1 2 3 Other</td>
<td></td>
</tr>
<tr>
<td>ICLUSIG® (ponatinib) tablets</td>
<td>mg</td>
<td></td>
<td>1 2 3 Other</td>
<td></td>
</tr>
<tr>
<td>NINLARO® (ixazomib) capsules</td>
<td>mg</td>
<td></td>
<td>1 2 3 Other</td>
<td></td>
</tr>
</tbody>
</table>

I certify that the above therapy is medically necessary and that the information provided is current, complete, and accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Takeda and its employees or agents to assist the patient in obtaining coverage for above-prescribed therapy and/or to assist the patient in initiating or continuing the above-prescribed therapy. I authorize Takeda Oncology 1Point™ to convey this prescription to the dispensing pharmacy.

**Sign Here**  Prescriber Signature: ___________________________ Date: ___________________________

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

**NOTE:** Patient Authorization is required to enroll in Takeda Oncology 1Point. If Patient Authorization is not obtained prior to submission of enrollment form, the prescriber authorizes Takeda to email Patient for completion.

**PATIENT AUTHORIZATION FOR TAKEDA ONCOLOGY 1POINT**

I understand that Takeda Oncology 1Point is a prescription assistance service offered by Millennium Pharmaceuticals Inc. ("Takeda") to help eligible patients who have been prescribed Takeda Oncology medication obtain financial assistance and access other patient support programs provided by Takeda Oncology 1Point.

I authorize my healthcare providers, pharmacy, and health plans to share my personal and medical information, including information about my insurance, prescriptions, medical condition, and health ("Protected Health Information") with and between Takeda and its present or future affiliates, including the affiliates and service providers that work on behalf of Takeda Oncology 1Point (together the "Takeda Group"), to 1) obtain information on insurance coverage for my medication indicated by my prescribing physician above; 2) establish my eligibility for benefits from my health plan or other programs, upon request; 3) coordinate prescription fulfillment of my medication as indicated by my prescribing physician above; 4) facilitate my access to Takeda Oncology 1Point and additional patient support programs provided by Takeda Oncology 1Point; 5) manage Takeda Oncology 1Point and additional patient support programs provided by Takeda Oncology 1Point; 6) provide me with adherence reminders and support; 7) contact me to evaluate the effectiveness of Takeda Oncology 1Point and other patient support programs provided by Takeda Oncology 1Point; 8) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Takeda Oncology 1Point and additional patient support programs provided by Takeda Oncology 1Point; 9) contact me for Takeda's internal business purposes, including quality control and assessment in connection with Takeda Oncology 1Point and other patient support programs provided by Takeda Oncology 1Point, as well as other Takeda Oncology products and services.

I understand that my pharmacy, health insurers, and third-party vendors may receive remuneration (payment) from the Takeda Group in exchange for processing my Protected Health Information to facilitate prescription assistance service, financial assistance, and/or for providing me with access to support services for the purposes described in this Patient Authorization.

I understand that once my Protected Health Information is disclosed, it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 1-844-T1POINT (1-844-817-6468) or by writing PO Box 4280, Gaithersburg, MD 20885-4280. If I do not sign this authorization, I understand my eligibility for health plan benefits and treatment by my doctor will not change, but I will no longer be eligible to participate in Takeda Oncology 1Point, or additional patient support programs provided by Takeda Oncology 1Point, or other Takeda Oncology programs and services. If I revoke this authorization, the Takeda Group will stop using or sharing my Protected Health Information (except as necessary to end my participation in Takeda Oncology 1Point), but my revocation will not affect uses and disclosures of my Protected Health Information previously disclosed in reliance on this authorization. I understand that this written authorization will remain valid for 5 years from the date of my signature, unless I revoke it earlier, or unless a shorter period is required under state laws. I understand that I may receive a copy of this authorization. *Restrictions apply.

**Sign Here**  Patient Signature: ___________________________ Date: ___________________________