ENTYVIO CONNECT ENROLLMENT AND CO-PAY FORMS

ENROLLMENT FORM INSTRUCTIONS

Entyvio® vedolizumab

1. BENEFITS INVESTIGATION ENROLLMENT FORM: **PURPLE**
   Complete the *Entyvio Connect* Enrollment form and make an enlarged copy of both sides of the patient's insurance card and pharmacy benefit card, if available.

2. PATIENT AUTHORIZATION AND CO-PAY CONSENT FORM: **PINK**
   Have your patient read and sign the Patient Authorization and Co-pay Consent Form. While patients are not required to sign the Patient Authorization and Co-pay Consent Form in order to receive Entyvio, signing may expedite the search for Entyvio therapy reimbursement and other support services including co-pay assistance. The *Entyvio Connect* Co-pay Program provides assistance with out-of-pocket costs of Entyvio for those patients who qualify. Fax the completed and signed Patient Authorization and Co-pay Consent Form to 1-877-488-6814.

3. Prescription information is needed if patient's insurance plan requires product to be dispensed by a specialty pharmacy. *Entyvio Connect* will triage the prescription to the in-network specialty pharmacy based on the patient's insurance plan. *Entyvio Connect* will also notify you which specialty pharmacy received the prescription. Your patient will be contacted by the specialty pharmacy to arrange for payment and confirm shipment location.

4. Fax completed forms along with a copy of the patient's insurance card and pharmacy and benefit card (if applicable) to 1-877-488-6814.

Prior to faxing, confirm that all forms are signed in the highlighted areas.

If you have any questions regarding this program, please call 1-855 ENTYVIO (1-855-368-9846), Monday to Friday, from 8 AM to 8 PM EST (except holidays) or visit www.EntyvioHCP.com.

For additional forms, see your Entyvio representative or visit www.EntyvioHCP.com.

ENTYVIO CONNECT BENEFIT INVESTIGATION ENROLLMENT FORM

Entyvio® vedolizumab

PATIENT INFORMATION (PLEASE ATTACH AN ENLARGED COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD AND/OR OTHER INSURANCE INFORMATION ALONG WITH THIS FORM)

☐ **Coverage Inquiry Only**

Patient Name (First, Middle Initial, Last):

Home Address: | City: | State: | Zip:

Home Phone: ( ) | Cell/Work Phone: ( ) | Birth Date: MM / DD / YEAR

Email: | Okay to call patient: ☐Yes/ ☐No

Primary Insurance (PI) Name: | PI Phone: ( )

☐**Commercial** ☐**Medicare/Medicaid** ☐**Pending Medicaid** ☐**No Insurance** PI Subscriber ID:

PI Subscriber Name: | PI Subscriber Birth Date: MM / DD / YEAR | Policy/Group ID #:

Secondary Insurance (SI) Name: | SI Phone: ( )

☐**Commercial** ☐**Medicare/Medicaid** ☐**Pending Medicaid** ☐**No Insurance** SI Subscriber ID:

SI Subscriber Name: | SI Subscriber Birth Date: MM / DD / YEAR | Policy/Group ID #:

HEALTHCARE PROVIDER INFORMATION

Healthcare Provider Name: | Clinic Name (if applicable):

Address: | City: | State: | Zip:

Contact Name: | Phone: ( ) | Fax: ( )

Do you prefer to be the sole point of contact? ☐Yes ☐No | DEA #: | Tax ID #: | Fax: ( ) (for additional summary of benefits)

NPI #:

SITE OF ADMINISTRATION ☐ **Same as above**

(IF FAX NUMBER IS PROVIDED, A COPY OF PATIENT'S SUMMARY OF BENEFITS WILL BE SENT TO THE SITE OF ADMINISTRATION)

Facility Name: | Contact Name:

Address: | City: | State: | Zip:

Phone: ( ) | Fax: ( ) | Site Tax ID #: | Site NPI #:

TREATMENT INFORMATION

Ulcerative Colitis			**Crohn's Disease**		
☐556.0	☐556.3	☐556.8	☐555.0	☐555.2	Has patient started therapy? ☐Yes ☐No If yes, last treatment date: MM / DD / YEAR
☐556.1	☐556.5	☐556.9	☐555.1	☐555.9	Prior biologic therapy? ☐Yes ☐No
☐556.2	☐556.6				Please list most recent therapy and date/duration:
☐Other					

PRESCRIPTION (REQUIRED FOR SPECIALTY PHARMACY BENEFIT)

Initiation: Entyvio 300 mg IV
Dispense:
☐Qty: _____vial(s) Refill_____times

Dosage and Directions for Use:
☐300 mg IV infusion at Week(s) _____
☐Other_____

Continuing: Entyvio 300 mg IV
Dispense:
☐Qty: _____vial(s) Refill_____times

Dosage and Directions for Use:
☐300 mg IV infusion at Week(s) _____
☐Other_____

Do you intend to buy & bill? ☐Yes ☐No

If no, please provide preferred specialty pharmacy _____ and phone number (if any): ( )

PRESCRIPTION AUTHORIZATION/CERTIFICATION OF MEDICAL NECESSITY/AUTHORIZATION TO RELEASE PATIENT INFORMATION

By signing this form, you are certifying that a) you authorize Takeda Pharmaceuticals America, Inc. and its agents or contractors to forward the above statement of medical necessity and furnish any information on this form to the insurer of the above-named patient and b) the described therapy above is medically necessary and c) you have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for Entyvio therapy to Takeda Pharmaceuticals America, Inc. and its agents or contractors for the purpose of seeking information related to coverage for Entyvio therapy and/or assisting in initiating or continuing Entyvio therapy.

Prescriber Signature | Date

*In New York, please attach copies of all prescriptions on Official New York State Prescription forms.

Phone: **1-855 ENTYVIO** (1-855-368-9846) Fax: 1-877-488-6814

For full Indications and Important Safety Information and complete dosage and administration instructions, please click here to read the Full Prescribing Information, including Medication Guide.

Entyvio CONNECT

93481 Nov. 2014

Takeda

ENTYVIO CONNECT PATIENT AUTHORIZATION AND CO-PAY CONSENT FORM

Entyvio vedolizumab

PATIENT AUTHORIZATION AND CO-PAY CONSENT FORM FOR *ENTYVIO CONNECT*

Entyvio Connect can provide certain services to you and on your behalf during the search for Entyvio therapy reimbursement and support services including co-pay assistance. The *Entyvio Connect* program is an agent of Takeda Pharmaceuticals America, Inc. In order to provide these services, *Entyvio Connect* will need to use your health information (called "Protected Health Information" or "PHI"), and to share it with your health plan and the pharmacy that will receive your doctor's prescription. This authorization will allow your healthcare providers, health plans, and health insurers that maintain PHI about you to disclose your PHI to *Entyvio Connect* so that *Entyvio Connect* may provide these services to you, or on your behalf.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

By signing this Authorization, I authorize my physician, health plans and pharmacy providers to disclose my Protected Health Information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription, to *Entyvio Connect* and its representatives, agents, and contractors for the following purposes: (1) to assist me in my health plan coverage for Entyvio, as well as to determine my eligibility for co-pay assistance; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies or services by a third party including, but not limited to specialty pharmacies; and (4) to register me in any applicable product registration program required for my treatment.

By checking the box below, I also authorize Takeda Pharmaceuticals America, Inc., its affiliates, and business partners to use my personal information to provide me with information and offers related to Entyvio, the diseases and conditions it treats, and related treatment options.

☐ I consent to receive product and disease-state information from Takeda Pharmaceuticals America, Inc., its affiliates, service providers, and co-promotion partners. I consent to be contacted through the following means (please check the boxes that apply and fill in your information. You can check more than one box.):

☐ Email: _____ ☐ Postal Mail, at the address below.

I understand that my PHI disclosed under this Authorization may no longer be protected by federal privacy law and may be re-disclosed by *Entyvio Connect.* I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits is not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to *Entyvio Connect*, PO Box 29219, Phoenix, AZ 85038-9219, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from today's date, unless a shorter period is provided for by state law.

Signature	Date:
Address:	

Patient's Printed Name:	Phone: ( )	☐ OK to leave a message at this number.

Please fax the signed form to 1-877-488-6814. For questions, please call *Entyvio Connect* at 1-855 ENTYVIO (1-855-368-9846), Monday to Friday, from 8 AM to 8 PM EST (except holidays).

For full Indications and Important Safety Information and complete dosage and administration instructions, please click here to read the Full Prescribing Information, including Medication Guide.

Takeda