VELCADE® (bortezomib) FOR INJECTION

Enrollment Form

Fax to 1-800-891-9843 or **call** 1-844-817-6468, Option 2, Mon-Fri, 8AM-8PM ET

VELCADE® (bortezomib) Patient Assistance Program

VELCADE PATIENT ASSISTANCE PROGRAM

If your patient is uninsured or the prescribed medication is not covered, the VELCADE Patient Assistance Program (PAP) may be able to provide eligible patients with a monthly supply of VELCADE (bortezomib) at no cost to them. Patients must meet certain financial and insurance coverage criteria to be eligible.

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

CARE PARTNER INFORMATION

Please complete this section if you would like the VELCADE Patient Assistance Program to communicate about the program primarily with your care partner on your behalf.

Name (First, Middle, Last): _____ Relationship: _____

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

Mobile: _____ OK to leave message? ❑ Yes ❑ No

FINANCIAL INFORMATION

Financial Information: Income documentation attached (Most recent IRS Form 1040, W-2 Form, SSI Letter, SSDI, Unemployment, Workers' Compensation, etc) ❑ Yes ❑ No

Size of Household (including patient): _____ Annual Gross Household Income:_____

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PATIENT AUTHORIZATION

By signing this form and accepting the benefits of the program, I certify that the information I have provided on this form, including information related to my income and insurance status, is truthful and complete. I understand that Takeda, or a vendor used by Takeda to carry out the Patient Assistance Program, may contact me to verify any information I have provided and that my participation in the program will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I certify I will not seek reimbursement or credit from any private insurer or government healthcare program for the Takeda Oncology medication provided under the PAP, nor will I sell or trade the Takeda Oncology medication provided under the PAP. 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") calculations. I acknowledge and understand that I am under no obligation whatsoever to purchase my prescribed Takeda Oncology medication or any other product manufactured by Takeda either before or after the prescribed Takeda Oncology medication is provided to me under the PAP. I understand that Takeda may modify or end the PAP at any time.

PATIENT ASSISTANCE PROGRAM ENROLLMENT

I have read, understand, and agree to the use of my personal information for the purposes described above.

❑ **By checking this box, I authorize the use of my personal information for Takeda marketing activities and consent to receiving marketing and promotional communication from Takeda. I herby give consent to Takeda, its affiliates, and their agents and representatives to send communications and information to me via the contact information I have provided. 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 my enrollment in the Velcade Patient Assistance Program or purchasing any goods or services.**

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

Legal Representative Signature: _____ Relationship: _____ Date: _____

By signing this form, I certify that the information provided above is current, complete, and accurate to the best of my knowledge. I certify that VELCADE is medically indicated for this patient and, that it will be used as directed. I further certify that I shall not seek reimbursement or credit from any insurer, healthcare plan or government program nor will I attempt to sell, barter, or return for credit any VELCADE provided under this program. I understand that I am under no obligation to prescribe or purchase VELCADE 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 **Physician Signature:** (no stamp allowed) _____ Date: _____

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PATIENT AUTHORIZATION FOR VELCADE PATIENT ASSISTANCE PROGRAM

I understand that the VELCADE Patient Assistance Program 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 the VELCADE Patient Assistance Program.*

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 the VELCADE Patient Assistance Program (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 the VELCADE Patient Assistance Program and additional patient support programs provided by the VELCADE Patient Assistance Program; 5) manage the VELCADE Patient Assistance Program and additional patient support programs provided by the VELCADE Patient Assistance Program; 6) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about the VELCADE Patient Assistance Program and additional patient support programs provided by the VELCADE Patient Assistance Program, or other Takeda Oncology products and services; and 7) contact me for Takeda's internal business purposes, including quality control and assessment in connection with the VELCADE Patient Assistance Program and other patient support programs provided by the VELCADE Patient Assistance Program, 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 1-844-817-6468 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 the VELCADE Patient Assistance Program, or additional patient support programs provided by the VELCADE Patient Assistance Program, or other Takeda Oncology programs and services. If I revoke this authorization, Takeda will stop using or sharing my Protected Health Information (except as necessary to end my participation in the VELCADE Patient Assistance Program), 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 1 year from the date of my signature unless I revoke it earlier or 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: _____

Legal Representative Signature: _____ Relationship: _____ Date: _____

Takeda