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) Reimbursement Assistance Program

Complete pages 1 and 2.

PRESCRIBER INFORMATION

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

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Primary Office Contact: _____

State License #:_____ NPI: _____ Tax ID #: _____

Shipment Address (if different from above): _____

City: _____ State: _____ ZIP:_____

PATIENT INFORMATION

Name (First, Middle, Last): _____ Date of Birth (MM/DD/YYYY):_____

Address: _____ City: _____ State: _____ ZIP: _____

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

PATIENT CLINICAL INFORMATION

ICD-10 Code: _____

Route of Administration: ❑ IV ❑ Subcutaneous Site of Service: ❑ Physician Office ❑ Hospital Outpatient Clinic ❑ Hospital Inpatient

CURRENT INSURANCE INFORMATION

Please attach copies of both sides of the patient's insurance card(s).

Insurance Plan: ❑ Medicare ❑ Medicaid ❑ Private/Commercial ❑ Other: _____ ❑ Patient has no insurance

Primary Insurer Name: _____ Insurer Phone: _____

Policy Holder Name (First, Middle, Last): _____ Policy Holder Date of Birth (MM/DD/YYYY): _____

Policy ID #: _____ Group #: _____

Secondary Insurer Name (First, Middle, Last): _____ Insurer Phone: _____

Policy Holder Name: _____ Policy Holder Date of Birth (MM/DD/YYYY): _____

Policy ID #: _____ Group #: _____

Has coverage for VELCADE therapy been specifically denied? ❑ No ❑ Yes (Please explain): _____

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PATIENT AUTHORIZATION FOR VELCADE REIMBURSEMENT ASSISTANCE PROGRAM

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

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 VRAP (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 VRAP and additional patient support programs provided by VRAP; 5) contact me to evaluate the effectiveness of VRAP and other patient support programs provided by VRAP; 6) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about VRAP and additional patient support programs provided by VRAP, 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 VRAP and other patient support programs provided by VRAP, 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 52100, Phoenix, AZ 85072. 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 VRAP, or additional patient support programs provided by VRAP, 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 VRAP), 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: _____

If you want to apply for optional Patient Assistance Program (PAP), please complete page 3 along with pages 1 and 2.

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OPTIONAL

Enrollment Form

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VELCADE® (bortezomib) Patient Assistance Program

[OPTIONAL] 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.

PATIENT FINANCIAL INFORMATION

❑ Check here if applying for the Patient Assistance Program for your patient

Patient's income documentation attached (1040 IRS Forms, SSI Letter, SSDI, Unemployment, Workers' Compensation, etc.) ❑ Yes ❑ No

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

PATIENT ASSISTANCE PROGRAM – FINANCIAL AUTHORIZATION

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: _____

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 (PAP), 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. 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.

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

Takeda