CO-PAY ASSISTANCE AND NURSE SUPPORT ENROLLMENT FORM

EntyvioCONNECT | Entyvio vedolizumab

ELIGIBILITY REQUIREMENTS (PLEASE READ BEFORE COMPLETING THIS FORM)

This offer cannot be used if you are a beneficiary of, or any part of your prescription is covered by: (1) any federal or state healthcare program (Medicare, Medicaid, TRICARE, etc.), including a state pharmaceutical assistance program, (2) the Medicare Prescription Drug Program (Part D), or if you are currently in the coverage gap, or (3) insurance that is paying the entire cost of the prescription.

PATIENT INFORMATION

Patient Name:			
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell/Work Phone:	Birth Date: MM/DD/YEAR	
Email:		Gender: ☐ Male ☐ Female	

Question	Answer
If you're unavailable when we call, is it okay for us to leave a message including the prescription name, Entyvio?	☐ Yes ☐ No
Do you certify that you currently have commercial insurance that covers a portion of your prescription costs for Entyvio?	☐ Yes ☐ No
Do you certify that you are not enrolled in any federal or state healthcare program (Medicare, Medicaid, TRICARE, etc), including a state pharmaceutical assistance program?	☐ Yes ☐ No
Do you certify that you will not seek reimbursement from any other plan or program (Flexible Spending Account [FSA], Health Savings Account [HSA], Health Reimbursement Account [HRA], etc.) for any out-of-pocket costs covered by the Co-pay Assistance Program?	☐ Yes ☐ No
Do you understand that you or your doctor will need to submit your Explanation of Benefits (EOB) following each infusion, and that the Program cannot provide co-pay assistance without an EOB?	☐ Yes ☐ No

By signing below, I authorize my physician, health insurance, and pharmacy providers to disclose my personal 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 ("Personal Health Information"), to Takeda Pharmaceuticals U.S.A., Inc., including the affiliates and service providers that work on Takeda's behalf in connection with the EntyvioConnect Patient Support Program (the "Companies"). The Companies will use my Personal Health Information for the purpose of facilitating the provision of the EntyvioConnect Patient Support Program products, supplies, or services as selected by me or my physician and may include (but not be limited to) verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, and other related programs. I understand that employees of the Companies only see my Personal Health Information in connection with administering the EntyvioConnect Patient Support Program or as otherwise required or allowed under the law. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, my Personal Health Information disclosed under this Authorization may no longer be protected by federal privacy law. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Policy available at http://www.takeda.us/home/privacy_policy.aspx. I understand that such 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. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way my physician, health insurance, and pharmacy providers treat me. I also understand that if I do not sign this Authorization, I will not be able to receive EntyvioConnect Patient Support Program products, supplies, or services.

PHYSICIAN INFORMATION

Physician Name:			Fax:
Site Name:			Office Contact Name:
Address:			NPI#:
City:	State:	Zip:	Diagnosis Code:
Phone:			

NURSE SUPPORT PROGRAM

☐ I would like to be contacted to learn about nurse support.

Patient Signature:	Date:
Patient's Printed Name:	

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

Please click here to read the full Prescribing Information, including Medication Guide.

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