

3 CO-PAY ASSISTANCE PROGRAM ONLY ENROLLMENT

HOW TO ENROLL

The *Entyvio Connect* Co-Pay Assistance Program provides help with out-of-pocket costs for those patients who qualify.*

3 CO-PAY ASSISTANCE ONLY ENROLLMENT FORM If your office determines that a Benefit Investigation is not needed, use this form to enroll your patient in the Co-pay Assistance Program only.

The patient should complete and sign **3** Co-pay Assistance Only Enrollment Form. Fax the completed and signed form to **1-877-488-6814**.

Prior to faxing, confirm that all attestation questions have been answered and that all highlighted areas have been signed.

***Eligibility Requirements:** 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.

Click [here](#) for a Co-pay Assistance Only Enrollment Form you can fill out.



For questions, please call **1-855-ENTYVIO (1-855-368-9846)**, Monday to Friday, from **8 AM to 8 PM EST (except holidays)**

Please see **Indications and Important Safety Information** on next page.

3 CO-PAY ASSISTANCE ONLY 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: / / _____

Email: _____ Gender: Male Female

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 this Authorization, I authorize my physician 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 *Entyvio Connect* and its representatives, agents, and contractors for the purpose of facilitating the provision of products, supplies or services by a third party including, but not limited to specialty pharmacies and co-pay assistance. I understand that my Personal Health Information 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.

Patient Signature: _____ Date: _____

Patient's Printed Name: _____

PHYSICIAN INFORMATION

Physician Name: _____ Fax: () _____

Site Name: _____ Office Contact Name: _____

Address: _____ NPI #: _____

City: _____ State: _____ Zip: _____ Diagnosis Code: _____

Phone: () _____

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, please see page 3. Please click here to read the full Prescribing Information, including Medication Guide.

ENTYVIO is a trademark of Millenium Pharmaceuticals, Inc., registered with the U.S. Patent and Trademark Office, and is used under license by Takeda Pharmaceuticals America, Inc. © 2016 Takeda Pharmaceuticals U.S.A., Inc. All rights reserved. April 2016 USD/VED/16/0050

INDICATIONS: ENTYVIO (vedolizumab)

Adult Ulcerative Colitis (UC)

Adult patients with moderately to severely active UC who have had an inadequate response with, lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids:

- inducing and maintaining clinical response
- inducing and maintaining clinical remission
- improving endoscopic appearance of the mucosa
- achieving corticosteroid-free remission

Adult Crohn's Disease (CD)

Adult patients with moderately to severely active CD who have had an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids:

- achieving clinical response
- achieving clinical remission
- achieving corticosteroid-free remission

IMPORTANT SAFETY INFORMATION

- ENTYVIO (vedolizumab) for injection is contraindicated in patients who have had a known serious or severe hypersensitivity reaction to ENTYVIO or any of its excipients.
- Infusion-related reactions and hypersensitivity reactions including anaphylaxis have occurred. Allergic reactions including dyspnea, bronchospasm, urticaria, flushing, rash, and increased blood pressure and heart rate have also been observed. If anaphylaxis or other serious allergic reactions occur, discontinue administration of ENTYVIO immediately and initiate appropriate treatment.

IMPORTANT SAFETY INFORMATION (continued)

- Patients treated with ENTYVIO are at increased risk for developing infections. Serious infections have been reported in patients treated with ENTYVIO, including anal abscess, sepsis (some fatal), tuberculosis, salmonella sepsis, Listeria meningitis, giardiasis, and cytomegaloviral colitis. ENTYVIO is not recommended in patients with active, severe infections until the infections are controlled. Consider withholding ENTYVIO in patients who develop a severe infection while on treatment with ENTYVIO. Exercise caution in patients with a history of recurring severe infections. Consider screening for tuberculosis (TB) according to the local practice.
- Although no cases of PML have been observed in ENTYVIO clinical trials, JC virus infection resulting in progressive multifocal leukoencephalopathy (PML) and death has occurred in patients treated with another integrin receptor antagonist. A risk of PML cannot be ruled out. Monitor patients for any new or worsening neurological signs or symptoms. Typical signs and symptoms associated with PML are diverse, progress over days to weeks, and include progressive weakness on one side of the body or clumsiness of limbs, disturbance of vision, and changes in thinking, memory, and orientation leading to confusion and personality changes. If PML is suspected, withhold dosing with ENTYVIO and refer to a neurologist; if confirmed, discontinue ENTYVIO dosing permanently.
- There have been reports of elevations of transaminase and/or bilirubin in patients receiving ENTYVIO. ENTYVIO should be discontinued in patients with jaundice or other evidence of significant liver injury.
- Prior to initiating treatment with ENTYVIO, all patients should be brought up to date with all immunizations according to current immunization guidelines. Patients receiving ENTYVIO may receive non-live vaccines and may receive live vaccines if the benefits outweigh the risks.
- Most common adverse reactions (incidence $\geq 3\%$ and $\geq 1\%$ higher than placebo): nasopharyngitis, headache, arthralgia, nausea, pyrexia, upper respiratory tract infection, fatigue, cough, bronchitis, influenza, back pain, rash, pruritus, sinusitis, oropharyngeal pain, and pain in extremities.

Please click [here](#) to read the full Prescribing Information, including Medication Guide.