

ENTYVIO CONNECT COVERAGE AND CO-PAY ENROLLMENT

HOW TO ENROLL

1 BENEFIT INVESTIGATION ENROLLMENT FORM Complete this 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 Have your patient complete and sign this form. While patients are not required to sign the Patient Authorization and Co-pay Consent Form in order to receive Entyvio, signing allows your patient to be enrolled into the Co-pay Assistance Program. The *Entyvio Connect* Co-pay Assistance Program provides help with out-of-pocket costs of Entyvio for those patients who qualify.

The prescription section of **1** Benefit Investigation Enrollment Form is required if you or the patient's insurance plan prefers to have a specialty pharmacy (SP) ship Entyvio to your office. If you would like to use an SP but do not have a preference, please indicate that you do not wish to buy and bill on Form **1**. *Entyvio Connect* will triage the prescription to the in-network SP based on the patient's insurance plan and will make sure the selected SP has your patient's co-pay enrollment details. *Entyvio Connect* will also notify you of which SP received the prescription. Your patient will be contacted by the SP to arrange for payment, and you will be contacted to confirm shipment location.

Fax the completed and signed Forms **1** and **2** to **1-877-488-6814**. **Prior to faxing, confirm that all forms are complete and signed in the highlighted areas.**

Click [here](#) for the Coverage and Co-pay Enrollment Forms you can fill out.

Please see Indications and Important Safety Information on next page.

1 BENEFIT INVESTIGATION ENROLLMENT FORM
 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.
 Home Address: _____ State: _____ Zip: _____
 Home Phone: () _____ Cell/Work Phone: _____ Birth Date: / /
 Email: _____ Okay to call patient: Yes / No
 Primary Insurance (PI) Name: _____ PI Phone: () _____
 Commercial Medicare/Medicaid Pending Medicare No Insurance PI Subscriber ID: _____
 PI Subscriber Name: _____ PI Subscriber State: / / Policy/Group ID #: _____
 Secondary Insurance (SI) Name: _____ SI Phone: () _____
 Commercial Medicare/Medicaid Pending Medicare No Insurance SI Subscriber ID: _____
 SI Subscriber Name: _____ SI Subscriber Birth Date: / / 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: () _____
 NPI #: _____ (for additional summary of benefits)
 SITE OF ADMINISTRATION Same as above
 Facility Name: _____ Contact Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: () _____ Fax: () _____ Site Tax ID #: _____ Site NPI #: _____
 TREATMENT INFORMATION
 Ulcerative Colitis Crohn's Disease Has patient started therapy? Yes No
 ICD-9 code: _____ ICD-9 code: _____ If yes, last treatment date: / /
 OR OR Prior biologic therapy? Yes No
 ICD-10 code: _____ ICD-10 code: _____ Please list most recent therapy and date/duration:
 PRESCRIPTION (REQUIRED FOR SPECIALTY PHARMACY BENEFIT)
 Initiation: Entyvio 300 mg IV Continuing: Entyvio 300 mg IV
 Dispense: _____ via(s) Refill _____ times Dispense: _____ via(s) Refill _____ times
 DQy: _____ DQy: _____
 Dosage and Directions for Use: _____ Dosage and Directions for Use: _____
 B300 mg IV infusion at Week(s) B300 mg IV infusion at Week(s)
 DOther DOther
 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 you authorize Takeda Pharmaceutical America, Inc. and its agents or contractors to forward the above statement of medical necessity and provide any information on this form to the extent of the above medical plan and to the applicable therapy above as medically necessary and to your best interest from the patient identified above to their preferred representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, relevant medical and/or other patient information relating to the need for Entyvio therapy to Takeda Pharmaceutical America, Inc. and its agents or contractors for the purpose of making information related to coverage, the drug, and/or the medical necessity of continuing Entyvio therapy.
 Prescriber Signature: _____ Date: _____
 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 4; for complete dosage and administration, please click here to read the full Prescribing Information, including Medication Guide.
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2 PATIENT AUTHORIZATION AND CO-PAY CONSENT FORM FOR ENTYVIO CONNECT
 you and on your behalf during the search for Entyvio therapy or co-pay assistance. The Entyvio Connect program is an agent of to provide this support. Entyvio Connect will need to use your health plan or "PHI", and to share it with your health plan and the pharmacy authorization will allow your healthcare providers, health plans, and disclose your PHI to Entyvio Connect so that Entyvio Connect may
 RELEASE, COLLECT, USE, AND DISCLOSE
 with plans and pharmacy providers to that not limited to, information relating to my age, income, health insurance, as well as all information on to Entyvio Connect and its representatives, agents, ses: (1) to assist me in my health plan coverage for ability for co-pay assistance; (2) to communicate with my medical care; (3) to facilitate the provision of products, uding, but not limited to specialty pharmacies; and (4) to gistration program required for my treatment.
 rize Takeda Pharmaceutical America, Inc., its affiliates, all information to provide me with information and offers ditions it treats, and related treatment options.
 ase-state information from Takeda Pharmaceuticals bers, and co-promotion partners. I consent to be (Please check the boxes that apply and fill in your ne box.)
 Postal Mail, at the address below.
 er this Authorization may no longer be protected by sed by Entyvio Connect. I understand that I may refuse treatment, payment, enrollment or eligibility for benefits ization. I understand that I am entitled to a copy of this ancel this Authorization at any time by mailing a letter Connect, PO Box 29219, Phoenix, AZ 85038-9219, but ly information already used or disclosed through this er 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).
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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.