Takeda Patient Support

Cuvitru [Immune Globulin Subcutaneous (Human)] 20%

CUVITRU Patient Start Form

Fax pages 1-4 to **1-866-861-1752** | Phone: **1-866-861-1750** Please ensure patient reads and signs pages 3 and 4 for appropriate authorizations.

1 Prescribing Physician Information

Name (First, Last):

State License #:

NPI #:

Tax ID #:

PTAN #:

Street Address:

City:

State:

ZIP:

Office Contact:

Telephone:

Fax:

Email:

2 Patient Information

☐ Male ☐ Female

Patient Name (First, Middle Initial, Last):

DOB (MM/DD/YYYY):

Last 4 Digits of Social Security #:

Email:

Street Address:

City:

State:

ZIP:

Mobile Telephone:

Home Telephone:

Caregiver Name (First, Last):

Relationship to Patient:

Caregiver Telephone:

Caregiver Email:

3 Insurance Information

Please attach copies of both sides of patient's medical and prescription insurance cards.

☐ Check if patient does not have insurance.

Primary Insurance:

Insurance Telephone:

Policy ID #:

Group ID #:

Policy Holder Name:

Policy Holder DOB:

Pharmacy Plan Name:

Pharmacy Plan Telephone:

Policy ID #:

Group ID #:

RX BIN #:

RX PCN #:

Secondary Insurance:

Insurance Telephone:

Policy ID #:

Group ID #:

Policy Holder Name:

Policy Holder DOB:

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4 Diagnosis/Medical Assessment

Diagnosis (ICD-10):

IgA Level (mg/dL):

Pre Titer Level (mcg/mL):

IgG Level (mg/dL):

IgM Level (mg/dL):

Post Titer Level (mcg/mL):

5 CUVITRU Prescription, Training Request/Waiver, and Prescribing Physician Signature

Name (First, Middle Initial, Last):

DOB (MM/DD/YYYY):

☐ **For patients switching from intravenous immune globulin (human) (IVIG) treatment or adult patients switching from HYQVIA® [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] Solution:**

Establish the initial weekly dose by converting the monthly IVIG or HYQVIA dose into an equivalent weekly dose and increasing it using a dose adjustment factor.[1]

To calculate initial weekly dose = (Previous IVIG or HYQVIA dose [in grams] ÷ Number of weeks between IVIG or HYQVIA doses) x 1.30

☐ **For patients switching from subcutaneous immune globulin (SCIG):**

The weekly dose of CUVITRU (in grams) is recommended to be the same as the weekly dose of prior SCIG treatment (in grams).[1]

☐ **Patient is already on CUVITRU**

Prescription: CUVITRU® [Immune Globulin Subcutaneous (Human)] 20% Solution. Administer CUVITRU at regular intervals from daily up to every 2 weeks.[1]

Refills (as allowed by state or payer requirement)

Patient weight (kg):

Infusion parameters

Prescribed dose: (in grams) (in mL*) every day(s)

First 2 infusions infuse at: mL/hr/site

Subsequently may infuse up to: mL/hr/site

For calculating alternative dosing (2-7 times per week or biweekly), please see the Full Prescribing Information.

*To convert the dose (in grams) in mL, multiply total grams by 5. See Infusion Volume and Rate table on page 5 for the calculation of infusion volume and rate.

Number of subcutaneous site(s): ☐ 1 ☐ 2 ☐ 3 ☐ 4

SC needle length (check one): ☐ 4 mm ☐ 6 mm ☐ 9 mm ☐ 12 mm ☐ 14 mm

☐ **Prescriber additional instruction:**

☐ No known drug allergies ☐ Patient allergies (drug and non-drug):

☐ Special instructions:

Additional services

☐ Pharmacy to provide needles, syringes, durable medical equipment, and other ancillary supplies needed for infusion

☐ Pharmacy to provide anaphylactic kit:

Training

CUVITRU is intended for self-administration or administration by a caregiver. The patient or caregiver should be trained by a healthcare professional. Takeda Patient Support provides free infusion training services to all enrolled CUVITRU patients.

☐ **If you choose to opt out of these services, please check this box.**

Preferred site of care if not self-administered (check one)

Has a referral been sent to site of care? ☐ Yes ☐ No ☐ N/A

☐ Infusion suite ☐ Begin treatment in clinical setting, then transition to home care ☐ Prescriber's office ☐ Home infusion ☐ Hospital outpatient

Preferred Specialty Pharmacy:

Preferred Infusion Suite/Hospital Outpatient (if applicable):

By signing this form, I certify that therapy with CUVITRU is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current CUVITRU Prescribing Information and will be supervising Patient's treatment. I have received from Patient, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state law regulations, referenced medical and/or other patient information relating to CUVITRU therapy to Takeda Pharmaceutical Company Limited, including its agents or contractors, for the purpose of seeking information related to coverage and/or assisting in initiating or continuing CUVITRU therapy. I authorize Takeda Patient Support to transmit this prescription to the appropriate pharmacy designated by me, Patient, or Patient's plan. I agree that product provided through the Program shall only be used for Patient, must not be resold, offered for sale or trade or returned for credit.

Prescriber Signature (Required) Stamps not acceptable

SIGN

DISPENSE AS WRITTEN Date SUBSTITUTION PERMITTED Date

The prescriber is required to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in delay.

Takeda Patient Support

Patient Name:

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6 Patient HIPAA Authorization

Patient Name (First, Middle Initial, Last):

DOB (MM/DD/YYYY):

By signing the Patient Authorization section on the third page of this Takeda Patient Support Ig Enrollment Form, I authorize my physician, health insurance, and pharmacy providers (including any specialty pharmacy that receives my prescription) to disclose my protected 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 ("Protected Health Information"), to Takeda Pharmaceuticals U.S.A., Inc. and its present or future affiliates, including the affiliates and service providers that work on Takeda's behalf in connection with the Takeda Patient Support, Ig Patient Support Program (the "Companies"). The Companies will use my Protected Health Information for the purpose of facilitating the provision of the Takeda Patient Support, Ig 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 education, financial assistance with co-pays, patient assistance programs, and other related programs. Specifically, I authorize the Companies to 1) receive, use, and disclose my Protected Health Information in order to enroll me in Takeda Patient Support, Ig and contact me, and/or the person legally authorized to sign on my behalf, about Takeda Patient Support, Ig; 2) provide me, and/or the person legally authorized to sign on my behalf, with educational materials, information, and services related to Takeda Patient Support, Ig; 3) verify, investigate, and provide information about my coverage for HYQVIA, including but not limited to communicating with my insurer, specialty pharmacies, and others involved in processing my pharmacy claims to verify my coverage; 4) coordinate prescription fulfillment; and 5) use my information to conduct internal analyses. I understand that employees of the Companies only use my Protected Health Information for the purposes described herein, to administer the Takeda Patient Support, Ig Patient Support Program or as otherwise required or allowed under the law, unless information that specifically identifies me is removed. Further, I understand that my physician, health insurance, and pharmacy providers may receive financial remuneration from the Companies for providing Protected Health Information, which may be used for marketing purposes. I understand that Protected 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 revoke this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Notice available at www.takeda.com/privacy-notice/ or I may revoke this Authorization at any time by sending written notice of revocation to Takeda Patient Services 610 Crescent Executive Court, Suite 200 Lake Mary, FL 32746. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from the date it is signed and provided on the first page of this enrollment form, 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 Takeda Patient Support, Ig Patient Support Program products, supplies, or services.

Signature of Patient (Required) Date

*Legal Representative Name:

***Legal Representative Signature** Date

*Relationship to Patient:

*Required only if applicable.

Takeda Patient Support

Patient Name:

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6 Takeda Patient Support Enrollment

REQUIRED:

Takeda Patient Support Enrollment

By signing below, I am electing to enroll in Takeda Patient Support Services ("Services") and direct all disclosures of my Information in connection with such Services (which may include, but are not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance).

Signature of Patient (Required)/***Legal Representative Signature** Date

OPTIONAL:

Text Communication Agreement Terms & Conditions

By agreeing to these Takeda Patient Support ("Program") text message terms and conditions, you agree to receive text messages REQUIRED on your mobile device subject to the Terms & Conditions described below. You also consent to receive autodialed and/or prerecorded calls and/or text messages from or on behalf of the Program at the telephone number provided above. You understand that this consent is not a condition of purchase or use of the Program or of any Takeda product or service. Participants will receive an average of 5 text messages each month while enrolled in the Program. Such messages may be nonmarketing messages related to the Patient Support Program. There is no fee payable to Takeda to receive text messages; however, your carrier's message and data rates may apply.

You represent that you are the account holder for the mobile telephone number(s) that you provide to opt in to the Program. You are responsible for notifying Takeda immediately if you change your mobile telephone number. You may notify Takeda of a number change by calling 1-855-268-1825. Data obtained from you in connection with your registration for, and use of, this SMS service may include your phone number and/or email address, related carrier information, and elements of pharmacy claim information and will be used to administer this Program and to provide Program benefits such as information about your prescription, refill reminders, and Program updates and alerts.

Takeda will not be liable for any delays in the receipt of any SMS messages, as delivery is subject to effective transmission from your network operator. This Program is valid with most major US cellular providers.

Takeda may be required to contact the user if an adverse event is reported.

You agree to indemnify Takeda and any third parties texting on its behalf in full for all claims, expenses, and damages related to or caused, in whole or in part, by your failure to immediately notify us if you change your telephone number, including but not limited to all claims, expenses, and damages related to or arising under the Telephone Consumer Protection Act.

Takeda reserves the right to rescind, revoke, or amend the Program without notice at any time.

You can unsubscribe from this Program by texting STOP to 1-844-972-4268. For questions about this Program, text HELP or contact the customer support.

Consent for Marketing Information: By signing below, I authorize the use of my Information for Takeda marketing activities and consent to receiving marketing, market research opportunities, and promotional communications from Takeda. I hereby 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 above. I understand that this consent will be in effect until I cancel such authorization.

Signature of Patient (Required)/***Legal Representative Signature** Date

*Required only if applicable.

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Instructions for Completion of Form

- Complete sections 1-6 and **FAX PAGES 1-4 to 1-866-861-1752** and attach a copy of the patient's insurance card (front and back)
- Do not submit to Takeda any documentation of labs, clinical history, or other documents supporting the prior authorization process

1 **Prescribing Physician Information**

2 **Patient Information**

3 **Insurance Information**

4 **Diagnosis/Medical Assessment**

5 CUVITRU Prescription, Training Request/ Waiver, and Prescribing Physician Signature

- Please indicate the number of refills
- Check the appropriate box to specify whether you would like your patient to be trained by Takeda on self-administration or whether training has already occurred
- This is a prescription; a physician's signature and date are required

Infusion Volume and Rate[1]*

Infusion Parameters	First 2 Infusions		Subsequent Infusions	
	Patients <40 kg	Patients ≥40 kg	Patients <40 kg	Patients ≥40 kg
Volume (mL/site)	≤20	≤60	≤60	
Rate (mL/hr/site)	10-20		≤60	

*If the initial infusions are well tolerated, then subsequent infusions can begin at the maximum tolerated rate.

6 Patient HIPAA Authorization and Takeda Patient Support Enrollment

The patient signature is required to allow personal health information to be shared by third parties to Takeda to facilitate access to CUVITRU (insurance benefits, self-administration training, transfer RX to specialty pharmacy provider, etc.)

Checking the Takeda Patient Support Enrollment box allows patients to receive product support services from Takeda, if eligible

- Benefits investigation
- Infusion training (if applicable)
- Co-pay support (when applicable) and information about third-party financial assistance programs, as necessary
- Enrollment in Takeda Patient Support—Patient Support Manager assignment and product support services

What happens next?

- Once the completed form has been submitted to Takeda Patient Support, a dedicated Patient Support Manager will be assigned to your eligible patient
- The Patient Support Manager will contact the patient directly to inform him or her of the services available through Takeda Patient Support and to begin the insurance verification process
- The Patient Support Manager will work with the insurance company to determine insurance benefits
- The Patient Support Manager will assess the patient's eligibility for co-pay support (when applicable) and provide information about third-party financial assistance programs, as necessary
- If requested, the Patient Support Manager will set up Takeda-provided self-administration training services

INDICATION

CUVITRU is indicated as replacement therapy for primary humoral immunodeficiency (PI) in adult and pediatric patients ≥2 years. CUVITRU is for subcutaneous use only.

IMPORTANT SAFETY INFORMATION

WARNING: THROMBOSIS

- **Thrombosis may occur with immune globulin (IG) products, including CUVITRU. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity and cardiovascular risk factors.**
- **For patients at risk of thrombosis, administer CUVITRU at the minimum dose and infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk of hyperviscosity.**

Contraindications

- History of anaphylactic or severe systemic hypersensitivity reactions to subcutaneous administration of human IG.
- IgA-deficient patients with antibodies against IgA and a history of hypersensitivity to human IG.

Warnings and Precautions

See Full Prescribing Information for Warnings and Precautions for: Hypersensitivity, Renal Dysfunction/Failure, Thrombosis, Aseptic Meningitis Syndrome, Hemolysis, Transfusion-Related Acute Lung Injury, Transmittable Infectious Agents, and Interference with Lab Tests.

Adverse Reactions

The most common adverse reactions observed in clinical trials in ≥5% of patients were: local adverse reactions including mild or moderate pain, erythema, and pruritus, and systemic adverse reactions including headache, nausea, fatigue, diarrhea, and vomiting.

Drug Interactions

Passive transfer of antibodies may transiently interfere with the immune responses to live attenuated virus vaccines (e.g., measles, mumps, rubella and varicella).

Please click for Full Prescribing Information.

Reference: 1. CUVITRU [prescribing information]. Lexington, MA: Baxalta US Inc.

Takeda