Prescriber Referral Form

Glassia [Alpha$_1$-Proteinase Inhibitor (Human)]

Aralast NP [Alpha$_1$-Proteinase Inhibitor (Human)]

Steps for Prescribing Physician

1. Complete Sections 1-5 below.
2. Submit the completed form below to OnePath® by fax at **1-844-755-5751**.
   - Including copies of both sides of the patient's insurance card(s) is preferred but not mandatory.
   - Do not submit to Takeda any documentation of labs, clinical history, or other documents supporting the prior authorization process.
3. Look on the back of this form for next steps in getting your patient started on treatment with the help of OnePath services. You or your patient may call OnePath at **1-866-888-0660**.

Red indicates required information

1 Prescribing Physician

(a) Name (First, Last): _____ (b) Tax ID #: _____ (c) NPI #: _____

(d) Street Address: _____ (e) City: _____ (f) State: _____ (g) ZIP: _____

(h) Office Contact: _____ (i) Telephone: _____ (j) Fax: _____

2 Patient Information

(a) Patient Name (First, Middle Initial, Last): _____ (b) DOB (MM/DD/YYYY): _____

(c) Street Address: _____ (d) City: _____ (e) State: _____ (f) ZIP: _____

(g) Mobile Telephone (M): _____ (h) Work Telephone (W): _____ (i) Home Telephone (H): _____

(j) Email: _____

(k) ☐ Do not contact patient until Prescribing Physician has instructed to do so.

3 Insurance Information

Including copies of both sides of the patient's insurance card(s) is preferred but not mandatory.

(a) ☐ Check if patient does not have insurance.

(b) Primary Insurance: _____

(c) Insurance Telephone: _____

(d) Policy ID #: _____

(e) Group ID #: _____

(f) Policy Holder Name (First, Last) and Relationship to Patient: _____

(g) Secondary Insurance: _____

(h) Insurance Telephone: _____

(i) Policy ID #: _____

(j) Group ID #: _____

(k) Policy Holder Name (First, Last) and Relationship to Patient: _____

(l) Pharmacy Plan Name: _____ (m) Pharmacy Plan Telephone: _____

(n) Policy ID #: _____ (o) Group ID #: _____ (p) RX BIN #: _____ (q) RX PCN #: _____

(r) Medicare Part D: ☐ Yes ☐ No (s) Medicare Part D Plan Name: _____

(t) Subscriber: _____ (u) DOB: _____ (v) Subscriber ID #: _____ (w) Policy Group #: _____

4 Diagnosis/ Medical Assessment

(a) ICD-10-CM Diagnosis Code: _____

(b) Serum AAT Level: _____ mg/dL or _____ µm (c) Date: _____

(d) PFT: FEV, % Pred. _____ (e) Date: _____ (f) O_2 Therapy: _____ L/min (g) Date: _____

(h) Phenotype: _____ (i) Genetic Testing Results: _____

(j) Current or former smoker?
☐ Yes ☐ No
(k) If former smoker, date stopped: _____

5 Therapy

Select only one therapy.

(a) ☐ GLASSIA® [Alpha$_1$-Proteinase Inhibitor (Human)] (b) ☐ ARALAST® NP [Alpha$_1$-Proteinase Inhibitor (Human)]

(c) Infusion Location: ☐ Self-Administration (GLASSIA Only) ☐ Home Health ☐ Hospital/Infusion Center ☐ Healthcare Provider's Office

(d) ☐ Please provide my patient and/or his/her caregiver with training on the proper self-administration of GLASSIA.

(e) Preferred Specialty Pharmacy: _____ (f) Preferred Site of Care: _____

By signing this form, I certify that therapy with GLASSIA or ARALAST NP (as selected above) is medically necessary for the patient identified in this form ("Patient"). I have reviewed the current GLASSIA or ARALAST NP 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 GLASSIA or ARALAST NP 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 GLASSIA or ARALAST NP therapy. I authorize OnePath to transmit this medical or patient information 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): _____ **Date:** _____

stamps not acceptable

The prescriber is 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.

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OnePath® is PERSONALIZED PRODUCT SUPPORT.

What services are provided through OnePath?
OnePath provides a range of product support services throughout your patient's treatment journey. After enrolling in OnePath, your patients will be paired with a dedicated OnePath Team Member who will work one-on-one with them to:

- Navigate the health insurance process
- Enroll in the OnePath Co-Pay Assistance Program or discuss financial assistance options
- Coordinate medication delivery preferences
- Receive free self-administration training with a nurse (if appropriate)
- Learn about additional support, education, and community resources

Next steps for you and your patient:

Prescribing Physicians:

1. **Complete the Prescriber Referral Form** on the reverse side and submit to OnePath by fax.
2. **Talk to your patient about OnePath** personalized product support.
3. **Tear off patient information** at the bottom of this page and **provide it to your patient**.
4. **Inform your patient that OnePath will call them.** Ask your patient to answer a call from the OnePath number (1-866-888-0660). Alternatively, your patient may call OnePath directly or fax the Patient Authorization Form on the back of this packet to **1-844-755-5751**.

Your patient or their caregiver:

1. To initiate OnePath support, your patient or their caregiver should expect a call from OnePath (1-866-888-0660). Alternatively, they can contact OnePath directly or fax the Patient Authorization Form on the back of this packet to 1-844-755-5751.
2. Your patient must enroll in OnePath before the OnePath Team Member can provide product support services.

Who will communicate with my office?
A OnePath Team Member will call your office to confirm the receipt of the OnePath Referral Form and to discuss next steps. In addition, the Specialty Pharmacy will contact you concerning the prescription.

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OnePath® is HERE, EVERY STEP OF THE WAY.

OnePath is personalized product support.
OnePath provides a range of product support services throughout your Takeda treatment journey. From the moment you enroll in OnePath, your dedicated OnePath Team Member will work with you one-on-one throughout your pathway to treatment, and beyond. Your OnePath team is also available to help you access the Takeda medication you've been prescribed.

Your OnePath team is here to help you:

- Navigate the health insurance process
- Coordinate medication delivery with your specialty pharmacy
- Receive self-administration training (if selected)
- Access education, additional support, and resources

Co-Pay Assistance.
The OnePath Co-Pay Assistance Program helps eligible patients cover the expense of their co-pays, which includes coverage for certain administration charges. Eligible patients with commercial insurance may be covered at 100%, up to the program maximum.*

Enroll in OnePath now.

1. Keep the OnePath number (**1-866-888-0660**) in your phone so you don't confuse it with spam calls.
2. If you miss a call from us, please call us back at **1-866-888-0660**. You or your caregiver also can call us directly or fax the Patient Authorization Form on the back of this page to OnePath to enroll in the program.
3. Give OnePath your consent to provide personalized product support by filling out the Patient Authorization Form on the back of this page.

What happens next:
Once you have filled out the Patient Authorization Form (back of this page) and enrolled in OnePath, your OnePath team can begin providing personalized product support. This includes working with your physician's office, insurance company, and specialty pharmacy to access your prescribed therapy.

*The OnePath Copay Assistance Program (the Program) is not valid for prescriptions eligible to be reimbursed, in whole or in part, by Medicaid, Medicare (including Medicare Part D), Tricare, Medigap, VA, DoD, or other federal or state programs (including any medical or state prescription drug assistance programs). No claim for reimbursement of the out-of-pocket expense amount covered by the Program shall be submitted to any third party payer; whether public or private. The Program cannot be combined with any other rebate/coupon, free trial, or similar offer. Copayment assistance under the Program is not transferable. The Program only applies in the United States, including Puerto Rico and other U.S. territories, and does not apply where prohibited by law, taxed, or restricted. This does not constitute health insurance. Void where use is prohibited by your insurance provider. If your insurance situation changes, you must notify the Program immediately at 1-866-888-0660. Coverage of certain administration charges does not apply for patients residing in Massachusetts, Michigan, Minnesota, Rhode Island, and Vermont. Takeda reserves the right to rescind, revoke, or amend the Program at any time without notice.

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Patient Authorization Form

OnePath

Red indicates required information

Fax: **1-844-755-5751**
Phone: **1-866-888-0660**

Patient Name (First, Middle Initial, Last): _____

DOB (MM/DD/YYYY): _____

Patient or Legal Representative Authorization to Share Protected Health Information

I authorize any health plan, physician, healthcare professional, hospital, clinic, pharmacy provider or other healthcare provider (collectively, "Providers") to disclose my protected health information, including personal information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Information"), to Takeda Pharmaceutical Company Limited, its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "Takeda") in connection with the Company's provision of products, supplies, or services. I understand the Company will provide this Information to a specialty pharmacy to fulfill the prescription. This Information may also be used for internal uses by the Company, including data analysis. I understand that my Providers may receive financial remuneration from the Company for marketing services.

Further, the Company may use this Information for OnePath Product Support Services (if I agree below) such as 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.

Additionally, if I check the box below regarding marketing communications, I authorize the Company to use and disclose my Information to send marketing materials to me (as described below).

I understand that once disclosed to the Company, my Personal Health Information disclosed under this Authorization may no longer be protected by federal privacy law, including HIPAA. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by sending written notice of revocation to OnePath, 300 Shire Way, Lexington, MA 02421. 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 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 OnePath Product Support Program products, supplies, or services.

OnePath Enrollment (must check box for co-pay enrollment)

☐ I am electing to enroll in OnePath Product 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).

Patient/Legal Representative Signature: _____ **Date:** _____

Patient Name: _____

Legal Representative Name and Relationship: _____

Consent for Future Information (Optional)

☐ By checking this box, I authorize the use of my Information for Takeda marketing activities and consent to receiving marketing 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. I understand that this consent will be in effect until I cancel such authorization.

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Takeda