



PATIENT ASSISTANCE PROGRAM APPLICATION

P.O. BOX 66552

ST. LOUIS, MO 63166-6552

PHONE: 1-800-830-9159

FAX: 1-800-497-0928

*Patient Assistance Program representatives are available
Monday through Friday, 7:30 a.m. to 5:00 p.m. CT*



HOW DO I APPLY?

1. Complete Sections 1, 2, 3 and 4.
(YOU MUST SIGN SECTION 4)

Complete Section 5 if you
are enrolled in Medicare Part D

OR

Section 6 if you are eligible but not
enrolled in Medicare Part D.

2. Attach:

- Your original prescription
- Copies of your financial
documentation from last year
(SEE SECTION 2 FOR DETAILS)

3. Mail completed and signed application
with all your documentation to the
address above or have your healthcare
provider's office fax to 1-800-497-0928.

CAN I APPLY?

1. You are a legal resident in the United States.
2. You do not have prescription coverage
through private or government programs.
(SEE SECTIONS 5 AND 6 FOR GUIDELINES)
3. Your total household income does
NOT exceed:

Persons in Household	Annual Income
1	\$32,670
2	\$44,130
3	\$55,590
4	\$67,050
5	\$78,510

*Amounts may differ in Alaska and Hawaii
and may change annually.*

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Medication (generic)	Strength
ACTOS (pioglitazone HCl)	15 mg, 30 mg, 45 mg tablet
ACTOplus met (pioglitazone HCl + metformin HCl)	15 mg/500 mg, 15 mg/850 mg tablet
ACTOplus met XR (pioglitazone HCl + metformin HCl XR)	15 mg/1000 mg, 30 mg/1000 mg tablet
AMITIZA (lubiprostone)	8 mcg, 24 mcg capsule
DEXILANT (dexlansoprazole)	30 mg, 60 mg capsule
Duetact (pioglitazone HCl and glimepiride)	30 mg/2 mg, 30 mg/4 mg tablet
EDARBI (azilsartan medoxomil)	40 mg, 80 mg tablet
ROZEREM (ramelteon)	8 mg tablet
ULORIC (febuxostat)	40 mg, 80 mg tablet

IMPORTANT: Please go to next page. Call 1-800-830-9159 if you need help.



Quantity of bottles supplied may vary based on patient prescription.

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XMP-00214

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK



SECTION 1: PATIENT INFORMATION

Last Name		First Name	
Home Address			
City	State	Zip	
Preferred Daytime Phone Number ()			
Social Security Number (or Green Card or Visa Number)			
Are you <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		Date of Birth (mm/dd/yyyy)	
US Resident <input type="checkbox"/> YES <input type="checkbox"/> NO		US Veteran <input type="checkbox"/> YES <input type="checkbox"/> NO	
Deliver medication to: <input type="checkbox"/> PATIENT <input type="checkbox"/> HEALTHCARE PROVIDER <i>Delivery will be to patient unless otherwise indicated.</i>			
List all medications you currently take:			
Are you allergic to any medications (please list): <input type="checkbox"/> YES <input type="checkbox"/> NO			

SECTION 2: INSURANCE AND INCOME

Do you have prescription drug insurance from:
(check all that apply)

<input type="checkbox"/> Employer supplied	<input type="checkbox"/> Medicare Part D*
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Military benefits
<input type="checkbox"/> VA benefits	<input type="checkbox"/> Other
<input type="checkbox"/> State assistance	<input type="checkbox"/> None
<input type="checkbox"/> Private drug coverage	

Number of people in household** _____

Have you received Social Security Disability income for at least 2 years? ☐ YES ☐ NO

Total household** income:
\$_____ Monthly OR _____ Yearly

IMPORTANT:
Do you have a copy of last year's federal income tax return?
☐ YES ☐ NO

If you marked **YES** you must include a copy of last year's Federal Income Tax Return(s) for yourself, your spouse and your dependents.

If your income has changed significantly, or if you are no longer employed, send a new income statement or proof of unemployment.

If you marked **NO** you must include a copy of:

☐ IRS Form 4506T

☐ Social Security Yearly Benefits Statement (SSA-1099)

OR

☐ All income statements from jobs held last year

* Medicare Part D enrolled applicants must complete Section 5.
** Household = you, spouse and dependents.

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SECTION 3: HEALTHCARE PROVIDER INFORMATION

Last Name		First Name		DEA or State License Number	
Clinic Name (if applicable)					
Address					
City				State	Zip
Phone				Fax	
My signature certifies that if the product is sent to my office on behalf of the patient, I understand that it must be used for the patient listed on this application, and not be resold or offered for sale or trade, nor shall the patient nor any third-party payer, Medicare or Medicaid be charged for this product.					
Healthcare Provider Signature				Date	
X					

IMPORTANT: Please go to next page. Call 1-800-830-9159 if you need help.



XMP-00214

SECTION 4: PATIENT HIPAA AUTHORIZATION AND CERTIFICATION

I request and authorize my healthcare provider (listed in Section 3) and my health insurance company (if any) to disclose to Takeda Pharmaceuticals America, Inc. (Takeda) and its affiliated companies, or third-party contractors assisting Takeda in connection with the Takeda Patient Assistance Program (Program), all personal information relating to my medical condition, treatment and insurance coverage needed to determine my eligibility and administer my participation in the Program.

I may refuse to sign this authorization. If I refuse, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment, or affect my insurance enrollment or eligibility for insurance benefits. I may cancel this authorization at any time by mailing a letter of cancellation to Takeda at the address listed at the top of this application form. If I cancel this authorization, I will no longer be allowed to participate in the Program. Cancelling this authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed by Takeda, but will not affect disclosures made before that time.

I understand that once my personal information is disclosed to Takeda or its contractors, federal privacy laws may no longer protect the information from further disclosure. However, my personal information will not be used or disclosed by Takeda or its contractors for any purpose other than to determine my eligibility and to administer my participation in the Program. This authorization expires at the end of my participation in the Program.

I certify that the information on this form is accurate and complete to the best of my knowledge. I agree that Takeda and its contractors may also contact my health insurer to verify my insurance information.

Patient Signature

Date

X

SECTION 5: COMPLETE ONLY IF YOU ARE ENROLLED IN MEDICARE PART D

1. I understand that if approved for assistance, I will be able to receive the requested medication from the Takeda Patient Assistance Program (Program) for the remainder of the enrollment calendar year* for which my application was approved.
2. I will not seek the requested medication from my Medicare Part D plan for the remainder of the enrollment calendar year.*
3. I will not seek or accept reimbursement from my Medicare Part D Plan for medication received from the Program.
4. I will not seek true out-of-pocket (TrOOP) credit for any medication received from the Program because I understand that medication received from the Program will not count toward my TrOOP.
5. I give consent for the Program to disclose my enrollment in the Program to my Medicare Part D plan.
6. I agree to notify the Program immediately, in writing, if my prescription drug coverage changes in any way.

**Enrollment calendar year is the calendar year for which this application is being submitted.*

Medicare Drug Plan Name

Medicare Drug Plan Address

City

State

Zip

Patient Signature

Date

X

SECTION 6: COMPLETE ONLY IF YOU ARE ELIGIBLE FOR MEDICARE PART D – BUT NOT ENROLLED

1. I declare and affirm that I am eligible AND not currently enrolled in a Medicare Part D Plan.
2. I agree to notify the Program immediately, in writing, if my prescription drug coverage changes in any way.

Patient Signature

Date



X

IMPORTANT: Please go to next page. Call 1-800-830-9159 if you need help.



SECTION 7: FINAL CHECKLIST

Before you mail **OR** have your healthcare provider fax your application, please make sure:

- ☐ You have completed and signed Sections 1, 2 and 4
- ☐ Your healthcare provider has completed and signed Section 3
- ☐ Complete Section 5 ONLY if you are enrolled in Medicare Part D
- ☐ Complete Section 6 ONLY if you are eligible for Medicare Part D – but not enrolled
- ☐ You have attached:
 - ☐ your original prescription 
 - ☐ copies of your financial papers from last year (SEE SECTION 2 FOR DETAILS) 

Mail your complete application and other papers to:
TAKEDA PHARMACEUTICALS AMERICA, INC.
P. O. BOX 66552
ST. LOUIS, MO 63166-6552



OR

Have your healthcare provider's office fax to:
1-800-497-0928



What happens next?

**You and/or your healthcare provider will receive an answer
 from the Takeda Patient Assistance Program
 within 5 to 7 days after we receive your application.**

Please call
1-800-830-9159
 if you have questions.

**Representatives are available Monday through Friday
 from 7:30 a.m. to 5:00 p.m. CT**



Patient Assistance Within Reach