



ICLUSIG® (ponatinib)
RapidStart Request Form

How the RapidStart Program* helps

If your patient experiences a delay in insurance coverage determination of at least 5 days, they may be eligible to receive a 1-month supply of medication at no cost to them.

Patients must have a completed Takeda Oncology Here2Assist™ Enrollment Form on file to apply for the RapidStart Program. Terms and Conditions apply.*

How to enroll in the RapidStart Program

- COMPLETE ALL INFORMATION on page 3 in its entirety with your patient, including prescriber information, patient information, shipping information, treatment history, statement of medical necessity, prescription request, and authorization.
- **2. SIGN AND DATE** the form. Prescriber and patient (or legal representative) authorization is required in the form of an original signature following review of the prescriber authorization and the patient authorization sections.

IMPORTANT: Original signatures are required.

Please ensure original signatures for the prescriber and patient (or legal representative) are applied. Stamped signatures will not be accepted. Applications that do not include original signatures cannot be processed, and your patient's enrollment may be delayed.

3. FAX the completed and signed form to Takeda Oncology Here2Assist at 1-844-269-3038.

IMPORTANT: The RapidStart Request Form is only valid if received by fax.

Please see ICLUSIG® full Prescribing Information, including Boxed Warning.

^{*}The RapidStart Program provides a 1-month supply of treatment of the prescribed Takeda Oncology medication at no charge for eligible patients new to therapy experiencing a delay in insurance coverage determination of at least 5 business days. There is no purchase obligation by virtue of a patient's participation in the RapidStart Program. Patients must have an on-label, valid prescription for the Takeda Oncology medication and a medical necessity for being prescribed the Takeda Oncology medication. Patients must be enrolled in the Takeda Oncology Here2Assist Program to qualify. Free product for the RapidStart Program will only be available through the RapidStart Program noncommercial specialty pharmacy. A delay in coverage determination of at least 5 days is required for patients to be eligible for the RapidStart Program. The program may not be combined with any other offer and is not available to patients whose insurers have made a final determination to deny the patient coverage for the prescribed Takeda Oncology medication. Takeda reserves the right to change or end the program at any time. Benefits provided under the program are not transferable.

 $^{^\}dagger$ Separate program enrollment is required for the Takeda Oncology Here2Assist Program.



ICLUSIG® (ponatinib) RapidStart Request Form

Fax to 1-844-269-3038 or call 1-844-817-6468, Option 2, Monday-Friday, 8AM-8PM ET

Complete this additional ICLUSIG® (ponatinib) RapidStart Request Form for insured patients who are receiving their first prescription of ICLUSIG and are experiencing a delay in insurance coverage determination. The ICLUSIG RapidStart Program* may provide eligible patients with a 1-month supply of ICLUSIG at no cost to them. Terms and Conditions apply.*

Please see ICLUSIG® full Prescribing Information, including Boxed Warning.

| Address: | | City: | | State: | ZIP: |
|--|--|--|--|--|--|
| Phone: | Fax: | Primary | Office Contact: | | |
| State License #: | NPI: | Medicare/Medicaid Provider #: | | Reimbursement Cont | tact: |
| PATIENT INFORMATIO | N | | | | |
| | | Date of Birth | | | |
| | | City: | | | |
| | | OK to leave message? | | | |
| | | OK to leave message? 🔲 Yes 🔲 No | | | |
| SHIPPING INFORMATI | | | | | |
| Ship to patient's home address | s indicated above? 〔 | ☐ Yes ☐ No. Ship to address below | | | |
| Patient Name: | | Contact Person Name: | | Phone: | |
| Address: | | City: | | State: | ZIP: |
| IMPORTANT: Product cannot b | be shipped to a PO E | Sox. | | | |
| TREATMENT HISTORY | 1 | | | | |
| Previous therapies, if any: | | | | | |
| STATEMENT OF MEDI | ICAL NECESSITY | / | | | |
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| | | dication to be sent to your patient, th | | | |
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