ANNOTATED GUIDE

TAKHZYRO® (lanadelumab-flyo) injection

This guide can be used to help complete the **required components** of the TAKHZYRO Start Form before faxing it to OnePath®. Submission of this form, which also serves as a prescription, is the first step to getting your patients started on treatment. If the form is incomplete, OnePath will reach out to your office to collect the missing information, which may delay the onboarding process.

Please use a dark-colored pen when filling out the Start Form.

A PATIENT INFORMATION

Ensure the patient's full contact information is entered, including their email address and phone number. OnePath will need to establish contact with your patient before TAKHZYRO can be shipped. Tell your patient to save the OnePath number (1-866-888-0660) on their phone to avoid spam blockers.

B PATIENT CONSENT

Takeda requires a patient signature for 2 elections: **Patient Authorization** *and* **OnePath Patient Support Program and Communication Enrollment**. Patients should review the elections on page 3 (not shown) of the Start Form prior to signing.

C MARKETING COMMUNICATIONS

Your patient can choose to opt in to receive marketing communications, which include information about **upcoming patient events in their area** and other topics related to TAKHZYRO.

D DOSAGE

Before submitting this form to OnePath, be sure to select only 1 box that corresponds to your patient's age and preferred dosing frequency (every 2 weeks or every 4 weeks).

E DIAGNOSIS

To begin therapy, a diagnosis is required. Check 1 of the 2 boxes in section 4.

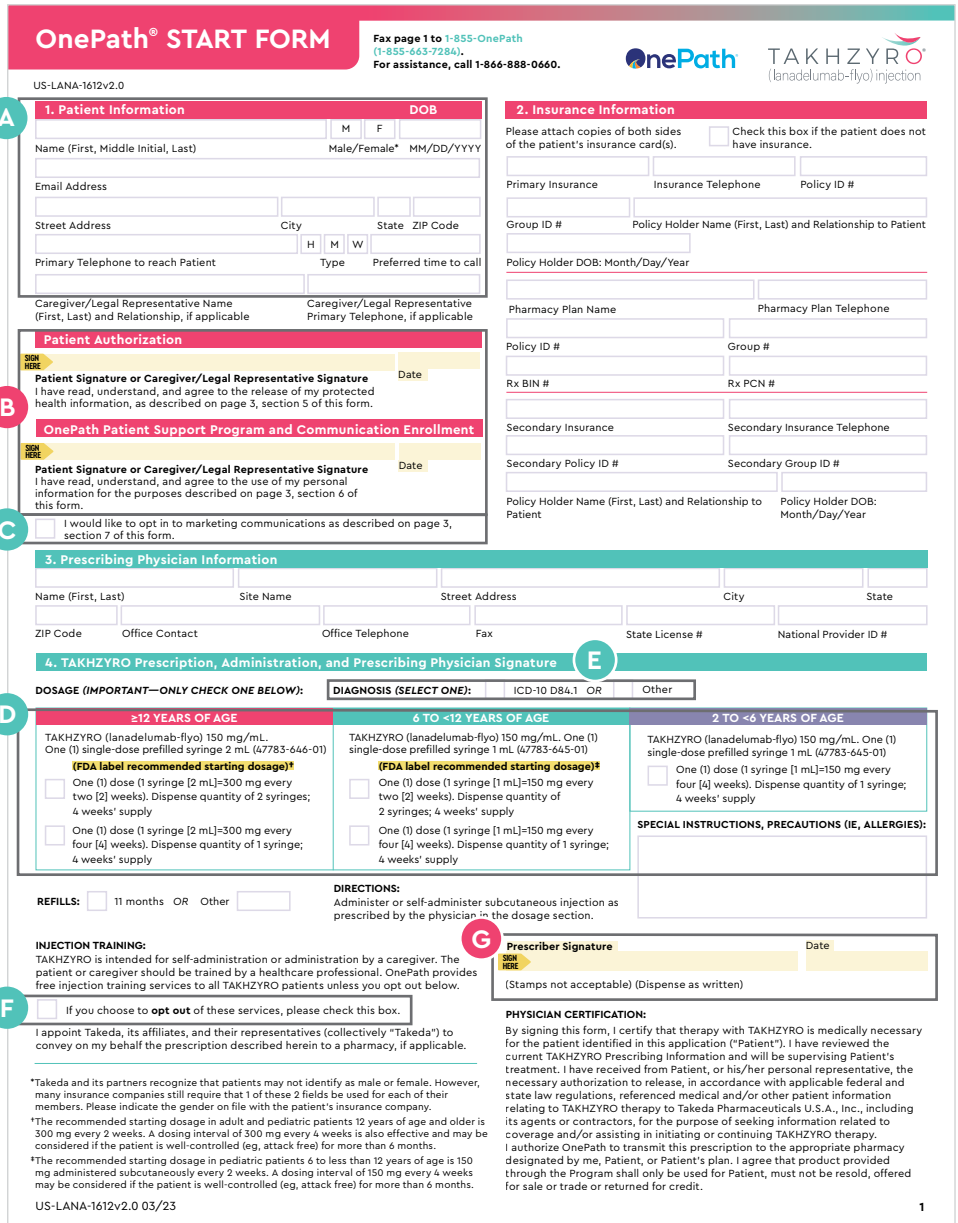
F TRAINING

By submitting this form to OnePath, your patient or their caregiver will automatically be signed up for administration training, and a Patient Support Manager will reach out to them for scheduling. *If you choose to opt your patient out of this service, you must check this box.*

G PRESCRIBER SIGNATURE

The prescriber's signature is required before faxing this form to OnePath.

Page 1



OnePath® START FORM

Fax page 1 to 1-855-OnePath (1-855-663-7284).
For assistance, call 1-866-888-0660.

OnePath TAKHZYRO (lanadelumab-flyo) injection

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A

1. Patient Information — DOB

Name (First, Middle Initial, Last) | Male/Female* | MM/DD/YYYY

Email Address

Street Address | City | State | ZIP Code

Primary Telephone to reach Patient | Type (H M W) | Preferred time to call

Caregiver/Legal Representative Name (First, Last) and Relationship, if applicable

Caregiver/Legal Representative Primary Telephone, if applicable

2. Insurance Information

Please attach copies of both sides of the patient's insurance card(s). ☐ Check this box if the patient does not have insurance.

Primary Insurance | Insurance Telephone | Policy ID #

Group ID # | Policy Holder Name (First, Last) and Relationship to Patient

Policy Holder DOB: Month/Day/Year

Pharmacy Plan Name | Pharmacy Plan Telephone

Policy ID # | Group #

Rx BIN # | Rx PCN #

Secondary Insurance | Secondary Insurance Telephone

Secondary Policy ID # | Secondary Group ID #

Policy Holder Name (First, Last) and Relationship to Patient | Policy Holder DOB: Month/Day/Year

Patient Authorization

SIGN HERE — Date

Patient Signature or Caregiver/Legal Representative Signature
I have read, understand, and agree to the release of my protected health information, as described on page 3, section 5 of this form.

B

OnePath Patient Support Program and Communication Enrollment

SIGN HERE — Date

Patient Signature or Caregiver/Legal Representative Signature
I have read, understand, and agree to the use of my personal information for the purposes described on page 3, section 6 of this form.

C ☐ I would like to opt in to marketing communications as described on page 3, section 7 of this form.

3. Prescribing Physician Information

Name (First, Last) | Site Name | Street Address | City | State

ZIP Code | Office Contact | Office Telephone | Fax | State License # | National Provider ID #

4. TAKHZYRO Prescription, Administration, and Prescribing Physician Signature E

DOSAGE (*IMPORTANT—ONLY CHECK ONE BELOW*): | **DIAGNOSIS (*SELECT ONE*):** ☐ ICD-10 D84.1 *OR* ☐ Other

D

≥12 YEARS OF AGE	6 TO <12 YEARS OF AGE	2 TO <6 YEARS OF AGE
TAKHZYRO (lanadelumab-flyo) 150 mg/mL. One (1) single-dose prefilled syringe 2 mL (47783-646-01)	TAKHZYRO (lanadelumab-flyo) 150 mg/mL. One (1) single-dose prefilled syringe 1 mL (47783-645-01)	TAKHZYRO (lanadelumab-flyo) 150 mg/mL. One (1) single-dose prefilled syringe 1 mL (47783-645-01)
(FDA label recommended starting dosage)†	**(FDA label recommended starting dosage)‡**	
☐ One (1) dose (1 syringe [2 mL]=300 mg every two [2] weeks). Dispense quantity of 2 syringes; 4 weeks' supply	☐ One (1) dose (1 syringe [1 mL]=150 mg every two [2] weeks). Dispense quantity of 2 syringes; 4 weeks' supply	☐ One (1) dose (1 syringe [1 mL]=150 mg every four [4] weeks). Dispense quantity of 1 syringe; 4 weeks' supply
☐ One (1) dose (1 syringe [2 mL]=300 mg every four [4] weeks). Dispense quantity of 1 syringe; 4 weeks' supply	☐ One (1) dose (1 syringe [1 mL]=150 mg every four [4] weeks). Dispense quantity of 1 syringe; 4 weeks' supply	

SPECIAL INSTRUCTIONS, PRECAUTIONS (IE, ALLERGIES):

REFILLS: ☐ 11 months *OR* Other ☐

DIRECTIONS:
Administer or self-administer subcutaneous injection as prescribed by the physician in the dosage section.

INJECTION TRAINING:
TAKHZYRO is intended for self-administration or administration by a caregiver. The patient or caregiver should be trained by a healthcare professional. OnePath provides free injection training services to all TAKHZYRO patients unless you opt out below.

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

I appoint Takeda, its affiliates, and their representatives (collectively "Takeda") to convey on my behalf the prescription described herein to a pharmacy, if applicable.

G

Prescriber Signature — Date

SIGN HERE

(Stamps not acceptable) (Dispense as written)

PHYSICIAN CERTIFICATION:
By signing this form, I certify that therapy with TAKHZYRO is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current TAKHZYRO 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 TAKHZYRO therapy to Takeda Pharmaceuticals U.S.A., Inc., including its agents or contractors, for the purpose of seeking information related to coverage and/or assisting in initiating or continuing TAKHZYRO therapy. I authorize OnePath 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.

*Takeda and its partners recognize that patients may not identify as male or female. However, many insurance companies still require that 1 of these 2 fields be used for each of their members. Please indicate the gender on file with the patient's insurance company.

†The recommended starting dosage in adult and pediatric patients 12 years of age and older is 300 mg every 2 weeks. A dosing interval of 300 mg every 4 weeks is also effective and may be considered if the patient is well-controlled (eg, attack free) for more than 6 months.

‡The recommended starting dosage in pediatric patients 6 to less than 12 years of age is 150 mg administered subcutaneously every 2 weeks. A dosing interval of 150 mg every 4 weeks may be considered if the patient is well-controlled (eg, attack free) for more than 6 months.

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1