COMPLETING THE START FORM

TAKHZYRO® (lanadelumab-flyo) injection

Submission of the TAKHZYRO Start Form, which also serves as a prescription form, is the first step to getting patients started on TAKHZYRO. Refer to this sample when filling out the actual TAKHZYRO Start Form. Please be mindful of the key areas called out below.

ICD-10 CHECK BOX To begin therapy, a diagnosis is required. A check box for the HAE ICD-10 code is available in section 4.

DOSE CHECK BOX The FDA label–recommended starting dose of TAKHZYRO is 300 mg every 2 weeks.* Be sure to check 1 dose and indicate which injection supplies are needed before submitting the form to OnePath®.

OnePath ENROLLMENT CHECK BOX Remind your patient to check this box to enroll in OnePath and receive product support services. *Please refer to the second page of the TAKHZYRO Start Form for additional information and guidance.*

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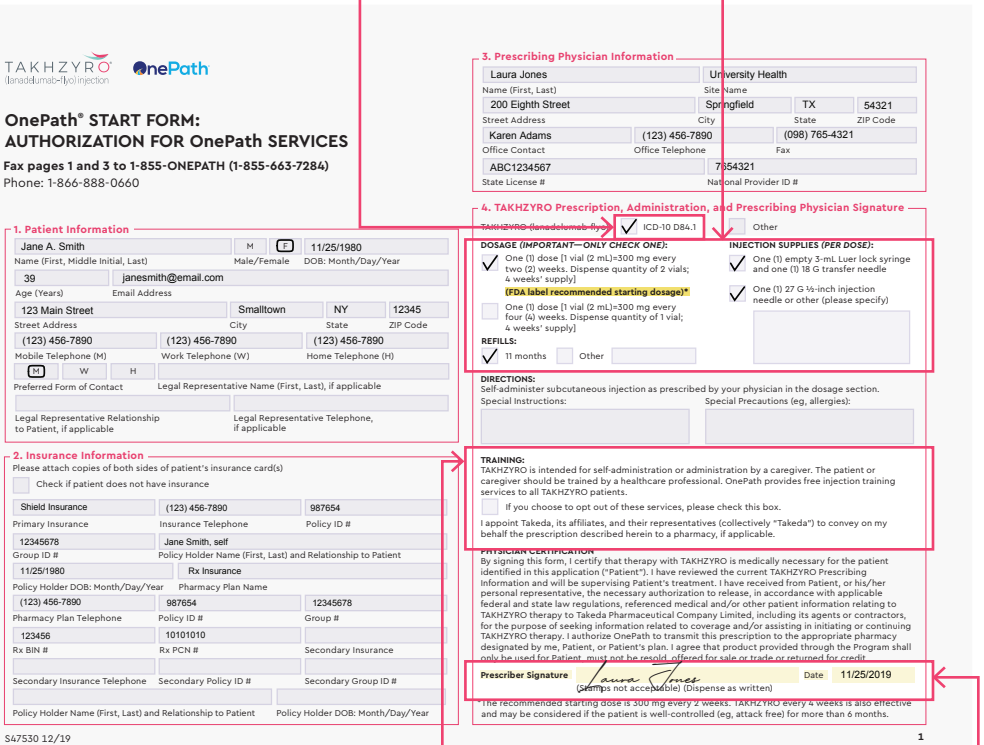

TAKHZYRO (lanadelumab-flyo) injection OnePath

OnePath® START FORM: AUTHORIZATION FOR OnePath SERVICES

Fax pages 1 and 3 to 1-855-ONEPATH (1-855-663-7284)
Phone: 1-866-888-0660

1. Patient Information
Jane A. Smith | M | F | 11/25/1980
Name (First, Middle Initial, Last) | Male/Female | DOB: Month/Day/Year
39 | janesmith@email.com
Age (Years) | Email Address
123 Main Street | Smalltown | NY | 12345
Street Address | City | State | ZIP Code
(123) 456-7890 | (123) 456-7890 | (123) 456-7890
Mobile Telephone (M) | Work Telephone (W) | Home Telephone (H)
M | W | H
Preferred Form of Contact | Legal Representative Name (First, Last), if applicable
Legal Representative Relationship to Patient, if applicable | Legal Representative Telephone, if applicable

2. Insurance Information
Please attach copies of both sides of patient's insurance card(s)
☐ Check if patient does not have insurance
Shield Insurance | (123) 456-7890 | 987654
Primary Insurance | Insurance Telephone | Policy ID #
12345678 | Jane Smith, self
Group ID # | Policy Holder Name (First, Last) and Relationship to Patient
11/25/1980 | Rx Insurance
Policy Holder DOB: Month/Day/Year | Pharmacy Plan Name
(123) 456-7890 | 987654 | 12345678
Pharmacy Plan Telephone | Policy ID # | Group #
123456 | 10101010
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

3. Prescribing Physician Information
Laura Jones | University Health
Name (First, Last) | Site Name
200 Eighth Street | Springfield | TX | 54321
Street Address | City | State | ZIP Code
Karen Adams | (123) 456-7890 | (098) 765-4321
Office Contact | Office Telephone | Fax
ABC1234567 | 7654321
State License # | National Provider ID #

4. TAKHZYRO Prescription, Administration, and Prescribing Physician Signature
~~TAKHZYRO (lanadelumab-flyo)~~ ☑ ICD-10 D84.1 ☐ Other

DOSAGE (IMPORTANT—ONLY CHECK ONE):
☑ One (1) dose [1 vial (2 mL)=300 mg every two (2) weeks. Dispense quantity of 2 vials; 4 weeks' supply]
(FDA label recommended starting dosage)*
☐ One (1) dose [1 vial (2 mL)=300 mg every four (4) weeks. Dispense quantity of 1 vial; 4 weeks' supply]

INJECTION SUPPLIES (PER DOSE):
☑ One (1) empty 3-mL Luer lock syringe and one (1) 18 G transfer needle
☑ One (1) 27 G ½-inch injection needle or other (please specify)

REFILLS:
☑ 11 months ☐ Other

DIRECTIONS:
Self-administer subcutaneous injection as prescribed by your physician in the dosage section.
Special Instructions: | Special Precautions (eg, allergies):

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.
☐ 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.

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 Pharmaceutical Company Limited, 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.

Prescriber Signature Laura Jones (Stamps not acceptable) Date 11/25/2019
(Dispense as written)

*The recommended starting dose is 300 mg every 2 weeks. TAKHZYRO every 4 weeks is also effective and may be considered if the patient is well-controlled (eg, attack free) for more than 6 months.

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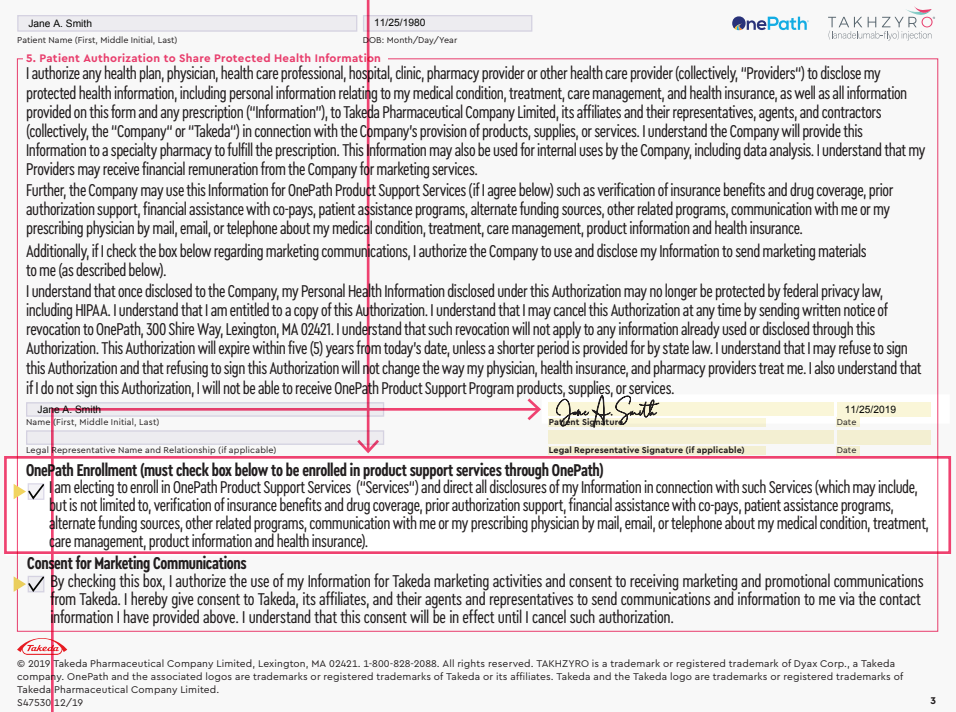

Jane A. Smith | 11/25/1980
Patient Name (First, Middle Initial, Last) | DOB: Month/Day/Year

OnePath TAKHZYRO (lanadelumab-flyo) injection

5. Patient Authorization to Share Protected Health Information
I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care 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.

~~Jane A. Smith~~ | Jane A. Smith | 11/25/2019
Name (First, Middle Initial, Last) | Patient Signature | Date
Legal Representative Name and Relationship (if applicable) | Legal Representative Signature (if applicable) | Date

OnePath Enrollment (must check box below to be enrolled in product support services through OnePath)
☑ 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 is 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).

Consent for Marketing Communications
☑ 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 above. I understand that this consent will be in effect until I cancel such authorization.

Takeda

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TRAINING By submitting this form to OnePath, your patient will be automatically signed up for self-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 the box.

SIGNATURES Signatures are required from both the prescribing physician and the patient. Before submitting the form to OnePath, ensure that both sections 4 and 5 are signed and dated.

Make sure to fill out the TAKHZYRO Start Form completely before submitting. If the form is incomplete, OnePath will reach out to you to collect the missing information, which may delay the onboarding process.

*The recommended starting dose is 300 mg every 2 weeks. TAKHZYRO every 4 weeks is also effective and may be considered if the patient is well-controlled (eg, attack free) for more than 6 months.

Please see Important Safety Information located on back and full Prescribing Information.

TAKHZYRO®
(lanadelumab-flyo) injection

INDICATION

TAKHZYRO is indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients ≥12 years of age.

IMPORTANT SAFETY INFORMATION

Hypersensitivity reactions have been observed. In case of a severe hypersensitivity reaction, discontinue TAKHZYRO administration and institute appropriate treatment.

Adverse Reactions: The most commonly observed adverse reactions (≥10% and higher than placebo) associated with TAKHZYRO were injection site reactions consisting mainly of pain, erythema, and bruising at the injection site; upper respiratory infection; headache; rash; myalgia; dizziness; and diarrhea. Less common adverse reactions observed included elevated levels of transaminases; one patient discontinued the trial for elevated transaminases.

Use in Specific Populations: The safety and efficacy of TAKHZYRO in pediatric patients <12 years of age have not been established.

No data are available on TAKHZYRO in pregnant women. No data are available on the presence of lanadelumab in human milk or its effects on breastfed infants or milk production.

To report SUSPECTED ADVERSE REACTIONS, contact Dyax Corp., a Takeda company, at 1-800-828-2088, or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see full Prescribing Information.

Takeda

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