# 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.

**A** **PATIENT INFORMATION**
Ensure the patient's full contact information is entered, including their email address and phone number.

**B** **ICD-10 D84.1 CHECK BOX**
To begin therapy, a diagnosis is required. Check the box in section 4.

**C** **DOSAGE CHECK BOX**
Before submitting this form to OnePath, be sure to check 1 dosage to indicate which injection supplies are needed.

**D** **TRAINING**
By submitting this form to OnePath, your patient will automatically be 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.*

**E** **OnePath ENROLLMENT CHECK BOX**
Remind your patient to check this box to enroll in OnePath and receive product support services

**F** **SIGNATURES**
Before submitting this form to OnePath, ensure sections 4 and 5 are signed and dated by *both* the physician *and* the patient.

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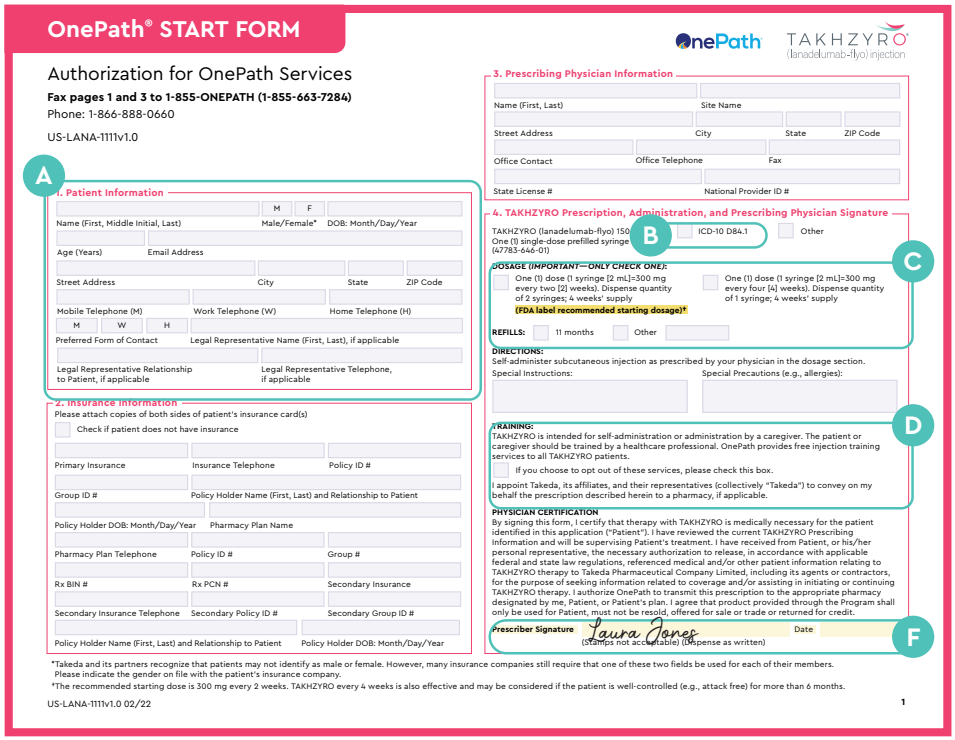

OnePath® START FORM

OnePath TAKHZYRO (lanadelumab-flyo) injection

Authorization for OnePath Services

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

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1. Patient Information

Name (First, Middle Initial, Last) | Male/Female* | DOB: Month/Day/Year
Age (Years) | Email Address
Street Address | City | State | ZIP Code
Mobile Telephone (M) | Work Telephone (W) | Home Telephone (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
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

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

TAKHZYRO (lanadelumab-flyo) 150 mg/1 mL One (1) single-dose prefilled syringe (47783-646-01)
B ICD-10 D84.1 | Other

C
DOSAGE (IMPORTANT—ONLY CHECK ONE):
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 [2 mL]=300 mg every four [4] weeks). Dispense quantity of 1 syringe; 4 weeks' supply
(FDA label recommended starting dosage)†
REFILLS: 11 months | Other

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

D
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.

F
Prescriber Signature Laura Jones Date
(Stamps not acceptable) (Dispense as written)

*Takeda and its partners recognize that patients may not identify as male or female. However, many insurance companies still require that one of these two fields be used for each of their members. Please indicate the gender on file with the patient's insurance company.
†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 (e.g., attack free) for more than 6 months.

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A
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.

Name (First, Middle Initial, Last)
Legal Representative Name and Relationship (if applicable)

F
Patient Signature Jane A. Smith Date
Legal Representative Signature (if applicable) Date

E
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.

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