Takeda Patient Support

HyQvia Patient Start Form

Fax pages 1-4 to **1-866-861-1752** | Phone: **1-866-861-1750**
Please ensure patient reads and signs **pages 3 and 4** for appropriate authorizations.

HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]

1 Prescribing Physician Information

Prescriber Name (First, Last):

Title:

State License #:

NPI #:

Tax ID #:

PTAN #:

Street Address:

City:

State:

Zip Code:

Office Contact:

Email:

Telephone:

Fax:

2 Patient Information

☐ Male ☐ Female

Patient Name (First, Middle Initial, Last):

DOB (MM/DD/YYYY):

Last 4 Digits of Social Security #:

Email:

Street Address:

City:

State:

Zip Code:

Mobile Telephone:

Home Telephone:

Caregiver Name (First, Last):

Relationship to Patient:

Caregiver Telephone:

Caregiver Email:

3 Insurance Information

Please attach copies of both sides of patient's medical and prescription insurance cards.

☐ Check if patient does not have insurance.

Primary Insurance:

Insurance Telephone:

Policy ID #:

Group ID #:

Policy Holder Name:

Policy Holder DOB (MM/DD/YYYY):

Pharmacy Plan Name:

Pharmacy Plan Telephone:

Policy ID #:

Group ID #:

Rx BIN #:

Rx PCN #:

Secondary Insurance:

Insurance Telephone:

Policy ID #:

Group ID #:

Policy Holder Name:

Policy Holder DOB (MM/DD/YYYY):

Please see Important Safety Information on page 6 and click for Full Prescribing Information, including Boxed Warning regarding Thrombosis.

Takeda Patient Support

Patient Name: _____

HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]

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4 Diagnosis/Medical Assessment

Diagnosis (ICD-10):

PI

IgA Level (mg/dL): _____ Pre-Titer Level (mcg/mL): _____

IgG Level (mg/dL): _____ Post-Titer Level (mcg/mL): _____

IgM Level (mg/dL): _____

CIDP

EMG/NCS: _____

Optional MRI: _____ Optional CSF: _____

Other: _____

5 HyQvia Prescription, Training Request/Waiver, and Prescribing Physician Signature

Name (First, Middle Initial, Last): _____ DOB (MM/DD/YYYY): _____ ☐ **Patient is already on HyQvia.**

Prescription: HyQvia® [Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase] Solution

Choose an indication below and calculate the patient's dose.

☐ **For Primary Immunodeficiency (PI)**

☐ Patient switching from intravenous immune globulin (human) (IVIG) treatment: Administer HyQvia at the same dose and frequency as the previous intravenous treatment, after the initial dose ramp-up.[1] See ramp-up schedule table on page 5 for calculation of ramp-up dosage.	Last IVIG (g): _____ Dosed Every _____ Weeks Patient Weight (kg): _____ Desired HyQvia Dose (g): _____ Every _____ Weeks
☐ Patient switching from subcutaneous immune globulin (human) (SCIG): Administer HyQvia at 300 to 600 mg/kg at 3-week or 4-week intervals, after the initial ramp-up.[1] See ramp-up schedule table on page 5 for calculation of ramp-up dosage.	Patient Weight (kg): _____ x Ordered Dose: _____ mg/kg ÷ 1,000 = Total Grams*: _____ Every _____ Weeks

☐ **For Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**

☐ If switching from IVIG (human) treatment, administer HyQvia at the same dose and frequency as the previous IV treatment, after the initial dose ramp-up.[1] See ramp-up schedule table on page 5 for calculation of ramp-up dosage.	Last IVIG (g): _____ Dosed Every _____ Weeks Patient Weight (kg): _____ Desired HyQvia Dose (g): _____ Every _____ Weeks

☐ Pharmacy to calculate ramp-up dose per the ramp-up schedule in the Full Prescribing Information.

_____ **Refills** (as allowed by state or payer requirement)

Maximum number of infusion site(s): ☐ 1 ☐ 2 ☐ 3

Infusion site(s)†: ☐ Middle to upper abdomen ☐ Thigh(s)

Pump: ☐ Peristaltic ☐ Syringe driver

High-flow 24 G needle length (check one): ☐ 6 mm ☐ 9 mm ☐ 12 mm ☐ 14 mm

*To calculate total infusion volume in mL, multiply total grams by 10.

†If 2 infusion sites are used, the infusion sites should be on opposite sides of the body. If using 3 sites, the sites should be 10 cm apart. Avoid bony prominences or areas that are scarred, inflamed, or infected.

☐ **Prescriber additional instruction:** _____

☐ No known drug allergies ☐ Patient allergies (drug and non-drug): _____

Special Instructions: _____

Preferred site of care if not self-administered (check one) **Has a referral been sent to site of care?** ☐ Yes ☐ No ☐ N/A

☐ Infusion suite ☐ Begin treatment in clinical setting, then transition to home care ☐ Prescriber's office ☐ Home infusion ☐ Hospital outpatient

Preferred Specialty Pharmacy: _____ Preferred Infusion Suite/Hospital Outpatient (if applicable): _____

Additional services and infusion training are available.

Check the box next to any of the services below. Check the last box if the patient opts out.

☐ Pharmacy to provide needles, syringes, durable medical equipment, and other ancillary supplies needed for infusion

☐ Name of pharmacy (to provide anaphylactic kit): _____

☐ Training

If HyQvia is intended for self-administration or administration by a caregiver, the patient or caregiver should be trained by a healthcare professional. Takeda Patient Support provides free infusion training services to all enrolled HyQvia patients.

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

By signing this form, I certify that therapy with HyQvia is medically necessary for the patient identified in this application ("Patient"). I have reviewed the current HyQvia 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 HyQvia 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 HyQvia therapy. I authorize Takeda Patient Support 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 (Required) Stamps not acceptable

SIGN _____ _____

DISPENSE AS WRITTEN Date SUBSTITUTION PERMITTED Date

The prescriber is required to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in delay.

Please see Important Safety Information on page 6 and click for Full Prescribing Information, including Boxed Warning regarding Thrombosis.

Takeda Patient Support

Patient Name:

HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]

Fax pages 1-4 to **1-866-861-1752** | Phone: **1-866-861-1750**

6 Patient HIPAA Authorization

Patient Name (First, Middle Initial, Last):

DOB (MM/DD/YYYY):

By signing the Patient Authorization section on the third page of this Takeda Patient Support Ig Enrollment Form, I authorize my physician, health insurance, and pharmacy providers (including any specialty pharmacy that receives my prescription) to disclose my protected health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form ("Protected Health Information"), to Takeda Pharmaceuticals U.S.A., Inc. and its present or future affiliates, including the affiliates and service providers that work on Takeda's behalf in connection with the Takeda Patient Support, Ig Patient Support Program (the "Companies"). The Companies will use my Protected Health Information for the purpose of facilitating the provision of the Takeda Patient Support, Ig Patient Support Program products, supplies, or services as selected by me or my physician and may include (but not be limited to) verification of insurance benefits and drug coverage, prior authorization education, financial assistance with co-pays, patient assistance programs, and other related programs. Specifically, I authorize the Companies to 1) receive, use, and disclose my Protected Health Information in order to enroll me in Takeda Patient Support, Ig and contact me, and/or the person legally authorized to sign on my behalf, about Takeda Patient Support, Ig; 2) provide me, and/or the person legally authorized to sign on my behalf, with educational materials, information, and services related to Takeda Patient Support, Ig; 3) verify, investigate, and provide information about my coverage for HyQvia, including but not limited to communicating with my insurer, specialty pharmacies, and others involved in processing my pharmacy claims to verify my coverage; 4) coordinate prescription fulfillment; and 5) use my information to conduct internal analyses. I understand that employees of the Companies only use my Protected Health Information for the purposes described herein, to administer the Takeda Patient Support, Ig Patient Support Program or as otherwise required or allowed under the law, unless information that specifically identifies me is removed. Further, I understand that my physician, health insurance, and pharmacy providers may receive financial remuneration from the Companies for providing Protected Health Information, which may be used for marketing purposes. I understand that Protected Health Information disclosed under this Authorization may no longer be protected by federal privacy law. I understand that I am entitled to a copy of this Authorization. I understand that I may revoke this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Notice available at www.takeda.com/privacy-notice/ or I may revoke this Authorization at any time by sending written notice of revocation to Takeda Patient Services 610 Crescent Executive Court, Suite 200 Lake Mary, FL 32746. 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 the date it is signed and provided on the first page of this enrollment form, 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 Takeda Patient Support, Ig Patient Support Program products, supplies, or services.

SIGN

Signature of Patient (Required) Date

SIGN

*Legal Representative Name:

***Legal Representative Signature** Date

*Relationship to Patient:

*Required only if applicable.

Please see Important Safety Information on page 6 and click for Full Prescribing Information, including Boxed Warning regarding Thrombosis.

Takeda Patient Support

Patient Name: _____

HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]

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7 Takeda Patient Support Enrollment (signature required for enrollment)

By signing below, I am electing to enroll in Takeda Patient Support Services ("Services") and direct all disclosures of my Information in connection with such Services (which may include, but are 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).

SIGN

Signature of Patient (Required)/***Legal Representative Signature** Date

*Required only if applicable.

8 Patient Consent for Communications

Marketing Communications

☐ By checking this box, I authorize the use of my Information for Takeda marketing activities and consent to receiving marketing, market research opportunities, 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.

Text Communications

☐ By checking this box, you agree to the Takeda Patient Support ("Program") text message terms and conditions below, and you agree to receive text messages on your mobile device subject to the Terms & Conditions. You consent to receive autodialed and/or prerecorded calls and/or text messages from or on behalf of the Program at the telephone number provided above. You understand that this consent is not a condition of purchase or use of the Program or of any Takeda product or service. Such messages may be nonmarketing messages related to the Patient Support Program. There is no fee payable to Takeda to receive text messages; however, your carrier's message and data rates may apply.

Text Communication Agreement Terms & Conditions

You represent that you are the account holder for the mobile telephone number(s) that you provide to opt in to the Program. You are responsible for notifying Takeda immediately if you change your mobile telephone number. You may notify Takeda of a number change by calling 1-866-861-1750. Data obtained from you in connection with your registration for, and use of, this SMS service may include your phone number and/or email address, related carrier information, and elements of pharmacy claim information and will be used to administer this Program and to provide Program benefits such as information about your prescription, refill reminders, and Program updates and alerts.

Takeda will not be liable for any delays in the receipt of any SMS messages, as delivery is subject to effective transmission from your network operator. This Program is valid with most major US cellular providers.

Takeda may be required to contact the user if an adverse event is reported.

You agree to indemnify Takeda and any third parties texting on its behalf in full for all claims, expenses, and damages related to or caused, in whole or in part, by your failure to immediately notify us if you change your telephone number, including but not limited to all claims, expenses, and damages related to or arising under the Telephone Consumer Protection Act.

Takeda reserves the right to rescind, revoke, or amend the Program without notice at any time.

You can unsubscribe from this Program by texting back STOP to any message or by calling 1-866-861-1750.

Takeda Patient Support

Patient Name: _____

HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]

Fax pages 1-4 to **1-866-861-1752** | Phone: **1-866-861-1750**

Before you fax this form, confirm you have:

- ☐ Completed **sections 1-8**
- ☐ Attached a copy of the patient's **insurance card (front and back)**
- ☐ Ensured the patient/legal representative has **signed pages 3 and 4**
- ☐ Not submitted any documentation of labs, clinical history, or other documents supporting the prior authorization process

1 Prescribing Physician Information

2 Patient Information

3 Insurance Information

4 Diagnosis/Medical Assessment

5 HyQvia Prescription, Training Request/Waiver, and Prescribing Physician Signature

- Please indicate the number of refills
- Check the appropriate box to specify whether you would like your patient to be trained by Takeda on self-administration or whether training has already occurred
- This is a prescription; a physician's signature and date are required

Infusion Parameters for Recombinant Human Hyaluronidase (Hy) and Immune Globulin Infusion 10% (Ig)[1]
Rate of Administration for Hy: 1-2 mL/min/site(s), and increase as tolerated

Rate of Administration for Ig:	Patients <40 kg (<88 lb)		Patients ≥40 kg (≥88 lb)	
	First 2 Infusions	Subsequent 2 or 3 Infusions	First 2 Infusions	Subsequent 2 or 3 Infusions
Interval (Minutes)	Rate/site (mL/hour)	Rate/site (mL/hour)	Rate/site (mL/hour)	Rate/site (mL/hour)
5-15	5	10	10	10
5-15	10	20	30	30
5-15	20	40	60	120
5-15	40	80	120	240
Remainder of Infusion	80	160	240	300

Initial Treatment Interval and Ramp-Up Schedule for PI[1]
For patients previously on another IgG treatment, the first dose should be given approximately 1 week after the last infusion of their previous treatment.

PI: Ramp-up schedule if switching from IVIG to HyQvia every 4 weeks[1]*

Week	Dose Interval	Dose
	Switch from IVIG	
1	1st dose	Total grams x 0.25
2	2nd dose	Total grams x 0.50
3	No Infusion	
4	3rd dose	Total grams x 0.75
5	No Infusion	
6	No Infusion	
7	4th dose	Total grams

Ramp-up schedule if switching from SCIG

Treatment Interval		4 Weeks	3 Weeks
1st Infusion	1st week	Total grams x 0.25	Total grams x 0.33
2nd Infusion	2nd week	Total grams x 0.50	Total grams x 0.67
3rd Infusion	4th week	Total grams x 0.75	Total grams
4th Infusion	7th week	Total grams	

Total grams=total monthly equivalent dose in grams.
*HyQvia can be dosed every 3 or 4 weeks.

Initial Treatment Interval and Ramp-Up Schedule for CIDP[1]
- Doses less than or equal to 0.4 g/kg can be administered without ramp-up
- Patients must be on stable doses of IVIG for 12 weeks before switching to HyQvia

Ramp-up schedule if switching from IVIG to HyQvia every 4 weeks[1]†

Week	Dose Interval	Dose
	Switch from IVIG	
1	No Infusion	
2	1st dose	Total grams x 0.25
3	2nd dose	Total grams x 0.25
4	3rd dose	Total grams x 0.50
6	4th dose	Total grams x 0.75
9	5th dose	Total grams

Total grams=total monthly equivalent dose in grams.
†HyQvia can be dosed every 2, 3, or 4 weeks.

6 Patient HIPAA Authorization

The patient signature is required to allow personal health information to be shared by third parties to Takeda to facilitate access to HyQvia (insurance benefits, self-administration training, transfer Rx to specialty pharmacy provider, etc.).

7 Takeda Patient Support Enrollment

The patient signature is required to enroll in Takeda Patient Support, and allows patients to receive product support and services from Takeda if eligible.

Check additional services and infusion training if needed, or check the last box if patient opts out.

8 Patient Consent for Communications

The patient must check the appropriate boxes to receive Takeda marketing and text communications.

What happens next?

- Once the completed form has been submitted to Takeda Patient Support, a dedicated Support Specialist will be assigned to your eligible patient
- The Support Specialist will contact the patient directly to inform him or her of the services available through Takeda Patient Support and to begin the insurance verification process
- The Support Specialist will work with the insurance company to determine insurance benefits
- The Support Specialist will assess the patient's eligibility for co-pay support (when applicable) and provide information about third-party financial assistance programs, as necessary
- If requested, the Support Specialist will set up Takeda-provided self-administration training services

Please see Important Safety Information on page 6 and click for Full Prescribing Information, including Boxed Warning regarding Thrombosis.

Takeda Patient Support

Patient Name: _____

HyQvia
[Immune Globulin Infusion 10% (Human) with Recombinant Human Hyaluronidase]

Fax pages 1-4 to **1-866-861-1752** | Phone: **1-866-861-1750**

INDICATIONS

HYQVIA is indicated for the treatment of primary immunodeficiency (PI) in adults and pediatric patients two years of age and older and for chronic inflammatory demyelinating polyneuropathy (CIDP) as maintenance therapy to prevent relapse of neuromuscular disability and impairment in adults. HYQVIA is for subcutaneous use only.

IMPORTANT SAFETY INFORMATION

WARNING: THROMBOSIS

- **Thrombosis may occur with immune globulin (IG) products, including HYQVIA. Risk factors may include advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors. Thrombosis may occur in the absence of known risk factors.**
- **For patients at risk of thrombosis, administer HYQVIA at the minimum dose and infusion rate practicable. Ensure adequate hydration in patients before administration.**
- **Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk of hyperviscosity.**

Contraindications

- History of anaphylactic or severe systemic hypersensitivity reactions to human IG
- IgA-deficient patients with antibodies to IgA and a history of hypersensitivity to human IG
- Known systemic hypersensitivity to hyaluronidase including Recombinant Human Hyaluronidase of HYQVIA
- Known systemic hypersensitivity to human albumin (in the hyaluronidase solution)

Warnings and Precautions

Hypersensitivity: Severe hypersensitivity reactions may occur, even in patients who have tolerated previous treatment with human IG. If a hypersensitivity reaction occurs, discontinue infusion immediately and institute appropriate treatment. IgA-deficient patients with antibodies to IgA are at greater risk of developing potentially severe hypersensitivity reactions, including anaphylaxis.

Thrombosis: Has been reported to occur following treatment with IG products, including HYQVIA and in the absence of known risk factors. In patients at risk, administer at the minimum dose and infusion rate practicable. Ensure adequate hydration before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.

Immunogenicity of Recombinant Human Hyaluronidase (rHuPH20): Non-neutralizing antibodies to the Recombinant Human Hyaluronidase component can develop. The clinical significance of these antibodies or whether they interfere with fertilization in humans is unknown.

Aseptic Meningitis Syndrome: Has been reported with use of IG, including HYQVIA and may occur more frequently in females. The syndrome usually begins within several hours to two days following IG treatment.

Conduct a thorough neurological exam on patients exhibiting signs and symptoms, to rule out other causes of meningitis. Discontinuing IG treatment has resulted in remission within several days without sequelae.

Hemolysis: HYQVIA contains blood group antibodies which may cause a positive direct antiglobulin reaction and hemolysis. Monitor patients for signs and symptoms of hemolysis and delayed hemolytic anemia and, if present, perform appropriate confirmatory lab testing.

Renal Dysfunction/Failure: Acute renal dysfunction/failure, acute tubular necrosis, proximal tubular nephropathy, osmotic nephrosis, and death may occur with intravenous (IV) use of IG products, especially those containing sucrose. Ensure patients are not volume depleted prior to infusion. In patients at risk due to pre-existing renal insufficiency or predisposition to acute renal failure, assess renal function before initiation and throughout treatment, and consider lower, more frequent dosing. If renal function deteriorates, consider discontinuation.

Spread of Localized Infection: Do not infuse HYQVIA into or around an infected area due to potential risk of spreading a localized infection.

Transfusion-Related Acute Lung Injury: Non-cardiogenic pulmonary edema may occur with IV administered IG. Monitor patients for pulmonary adverse reactions. If suspected, perform appropriate tests for presence of anti-neutrophil and anti-HLA antibodies in both product and patient serum. May be managed using oxygen therapy with adequate ventilatory support.

Transmittable Infectious Agents: Because HYQVIA is made from human plasma, it may carry a risk of transmitting infectious agents (e.g. viruses, other pathogens). No cases of transmission of viral diseases or variant Creutzfeldt-Jakob disease (vCJD) have been associated with HYQVIA.

Interference with Lab Tests: False positive serological test results and certain assay readings, with the potential for misleading interpretation, may occur as the result of passively transferred antibodies.

Adverse Reactions

The most common adverse reactions observed in >5% of patients in the clinical trials were:

Primary Immunodeficiency (PI): local adverse reactions including pain, erythema, edema, and pruritus, and systemic adverse reactions including, headache, antibody formation against Recombinant Human Hyaluronidase (rHuPH20), fatigue, nausea, pyrexia, and vomiting.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): local reactions, headache, pyrexia, nausea, fatigue, erythema, pruritus, increased lipase, abdominal pain, back pain, and pain in extremity.

Drug Interactions

Passive transfer of antibodies may transiently interfere with the immune responses to live attenuated virus vaccines (e.g., measles, mumps, rubella, and varicella).

Use In Specific Populations

Pregnancy: Limited human data are available on the use of HYQVIA during pregnancy. The effects of antibodies to the Recombinant Human Hyaluronidase on the human embryo or fetal development are unknown. It is not known whether HYQVIA can cause fetal harm when administered to a pregnant woman or if it can affect reproductive capacity. HYQVIA should be given to a pregnant woman only if clearly needed.

Please click for Full Prescribing Information.

Reference: 1. HyQvia [prescribing information]. Lexington, MA: Baxalta US Inc.

Takeda