ORZEYFUL™ Prescription Referral Form

Orzeyful™ oveporexton tablets (IV)

Takeda Patient Support
Your Source for Education and Access

Fax pages 1 and 2 to 1-844-409-0595
For assistance, call 1-877-223-4681 Monday through Friday, 8 AM to 8 PM ET

All fields marked * are required. Please complete all fields to avoid delays in processing.

1. Patient Information

*First name:	*MI:	◯ *US resident	*Address:		
*Last name:		*Gender: ◯ M ◯ F	*City:	*State:	*ZIP:
*DOB: (MM/DD/YYYY) / /	Preferred language other than English:		*Email:		
Home phone:	◯ Preferred ◯ OK to leave message		Alternate contact:		
Mobile phone:	◯ Preferred ◯ OK to leave message		Relationship:		
Best time to reach me: ◯ Morning ◯ Afternoon ◯ Evening			Alternate contact ph.:	◯ OK to leave message	

For patients under 18 or with a Legal Representative:

Name:	Phone:	Email:	Relationship: ◯ Parent ◯ Legal Representative

2. Patient Insurance Information

Please attach a copy of the front and back of patient's medical and prescription insurance card(s).
◯ Patient does NOT have insurance (leave remaining fields blank)

*Policy holder name:		*Relationship to patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other: _____		
*Phone:	*Member ID #:	Group #:	Rx PCN #:	Rx BIN #:

3. Prescriber Information

*First name:	*Last name:	*NPI:	
*Office/clinic/institution name:		*State license #:	*DEA #:
*Office contact name:		*Address:	
*Email:		*City:	*State:	*ZIP:
*Phone:	Preferred time to call:	*Fax:	

4. Patient's Medical History

***Diagnosis code (ICD-10)** ◯ Narcolepsy with cataplexy: G47.411 ◯ Other: _____ ◯ No Known Drug Allergies (NKDA)

◯ Concurrent medications: _____ ◯ Drug and other allergies: _____

5. Prescription Details (Controlled substance limits may apply)

***Dosing Information:** Twice-daily dosing. The first dose should be taken after awakening and the second dose 3 to 5 hours later.

◯ **ORZEYFUL 1 mg** QTY _____ Refills _____

◯ **ORZEYFUL 2 mg** QTY _____ Refills _____

Reduce dose to 0.5 mg for concomitant use with moderate CYP3A inhibitors

◯ **ORZEYFUL 0.5 mg** QTY _____ Refills _____

6. Quick Start Program Request (only required if requesting Quick Start)

☐ **Request Quick Start Program for New Patient** (provides eligible commercially insured patients access to ORZEYFUL at no cost for up to 12 shipments until insurance coverage is obtained)

Patient HIPAA Authorization and Takeda Patient Support Program Enrollment are required (see page 2). *Subject to eligibility and program terms. Takeda may change or end this program at any time. Each shipment is a 30-day supply.*

7. Prescriber Authorization

By signing this form, I certify that the prescribed Takeda product is medically necessary for the patient identified in this application ("Patient"). I have reviewed the associated 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 the requested medication to Takeda Pharmaceuticals U.S.A., Inc., including its agents or contractors (the "Company"), for the purpose of seeking information related to coverage and/or assisting in initiating or continuing therapy. I authorize Takeda Patient Support (the "Program") 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, and must not be resold, offered for sale or trade, or returned for credit or submitted for reimbursement to any third-party payer, including Medicare or Medicaid, either directly or indirectly. I understand that I am under no obligation to prescribe the requested medication or any other product manufactured by the Company, and I certify I have received nothing of value from the Company or its agents or representatives for prescribing a Company product.

SIGN HERE **Prescriber Signature** **Date (MM/DD/YYYY)**	SIGN HERE **Prescriber Signature** **Date (MM/DD/YYYY)**
Substitution NOT permitted. Dispense as written. Original signature required. Signature stamp not acceptable.	Substitution permitted. Original signature required. Signature stamp not acceptable.

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 outreach to the prescriber.

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8. Patient HIPAA Authorization

By signing below, 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 and any prescription ("Protected Health Information"), to Takeda Pharmaceuticals U.S.A., Inc. and its present or future affiliates and their representatives, agents, and contractors, including the affiliates and service providers that work on Takeda's behalf in connection with the Takeda Patient Support Program (collectively the "Companies"). The Companies will use my Protected Health Information for the purpose of facilitating the provision of the Takeda 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, alternate funding resources, 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 and contact me, and/or the person legally authorized to sign on my behalf, about Takeda Patient Support; 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; 3) verify, investigate, and provide information about my coverage for my prescribed Takeda product, 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 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 once my Protected Health Information is disclosed under this Authorization, it 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 cancel this Authorization and that instructions for doing so are contained in Takeda's Website Privacy Notice available at **www.takeda.com/privacy-notice/**. I can also revoke my Authorization by emailing **MedicalRecordsConsentForms@express-scripts.com** or by calling 1-877-223-4681. I understand that such cancellation 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 below, 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 Program products, supplies, or services. **I have read, understand, and agree to the release of my protected health information, as described above:**

SIGN HERE **Patient Signature or Legal Representative** **Date (MM/DD/YYYY)**

Legal Representative Name and Relationship to Patient (if applicable)

9. Takeda Patient Support Program 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, disease state/product education, 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). I understand that Takeda and its business partners may use and share with each other and with my healthcare providers, pharmacies, and health insurance plans, information about me, including sensitive health information, in connection with providing services to me under the Program, administering the Program, or as otherwise required for Takeda to meet its legal obligations. I agree Takeda may use my de-identified data for internal use. **I have read, understand, and agree to the use of my personal information for the purposes described above:**

SIGN HERE **Patient Signature or Legal Representative** **Date (MM/DD/YYYY)**

10. Text Messaging Agreement Terms and Conditions (Optional)

By agreeing to these Program text message terms and conditions, you agree to receive text messages on your mobile device subject to the Terms & Conditions described below. You also consent to receive autodialed and/or pre-recorded 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. Participants will receive an average of 5 text messages each month while enrolled in the Program. 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. 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 1-877-223-4681. 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 STOP to any message. For questions about this Program, text HELP or contact the customer support center at 1-877-223-4681.

SIGN HERE **Patient Signature or Legal Representative** **Date (MM/DD/YYYY)**

11. Patient Consent for Marketing and Research Communications (Optional)

By clicking the check box, I agree to usage of my sensitive health information, including phone number, address and email, to be used to receive research opportunities and marketing and promotional communications from Takeda, its affiliates and their agents and representatives. I understand this consent will be in effect until I revoke such consent.

☐ **I would like to opt in to communications as described above.**

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