TAKHZYRO (lanadelumab-flyo) injection

OnePath® START FORM: AUTHORIZATION FOR OnePath SERVICES

Phone: 1-866-888-0660 Fax: 1-855-ONEPATH (663-7284)

OnePath

1. Prescribing Physician Information

Name (First, Last) | Site Name

Street Address | City | State | ZIP Code

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

2. Patient Information

Name (First, Middle Initial, Last) | Male/Female | DOB: Month/Day/Year

Age (Years) | Last 4 digits of SS # | Email Address

Street Address | City | State | ZIP Code

Mobile Telephone (M) | Work Telephone (W) | Home Telephone (H) | Preferred Form of Contact: M W H

Caregiver Name (First, Last) | Relationship to Patient | Caregiver Telephone

3. 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 | Insurance Telephone | Secondary Policy ID # | Secondary Group ID #

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

4. TAKHZYRO Prescription, Administration, and Prescribing Physician Signature

TAKHZYRO (lanadelumab-flyo) ☐ ICD-10 D84.1 ☐ Other

DOSE *(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 dose)*

☐ One (1) dose [1 vial (2 mL)=300 mg every four (4) weeks. Dispense quantity of 1 vial, 4 weeks supply]

REFILLS: ☐ 11 months ☐ Other

DIRECTIONS:
Self-administer subcutaneous injection as prescribed by your physician in the dose section.

Special Instructions:

Special Precautions (eg, allergies):

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)

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 Shire Human Genetic Therapies, Inc., its affiliates, and their representatives (collectively "Shire") to convey on my behalf the prescription described herein to a pharmacy, if applicable.

Prescriber Signature | Date

(Stamps not acceptable) (Dispense as written)

5. Patient Authorization to Share Personal Health Information

I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Health Care Providers") to disclose my, or my child's, as applicable, personal health information, including information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription, as well as my or my child's, as applicable, personal health information obtained by Health Care Providers prior to the date of this authorization ("Personal Health Information"), to Shire, Human Genetic Therapies, Inc., its affiliates and their representatives, agents, and contractors (collectively, "Shire") and to receive financial remuneration from Shire in exchange for the following purposes: for Shire to provide product support services, including coordination of benefits and therapy; reimbursement support; investigating insurance coverage; communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance; and internal use by Shire, including data analysis. I understand that my Personal Health Information disclosed under this authorization may be re-disclosed by Shire and no longer protected by federal privacy laws. I understand, however, that Shire agrees to undertake reasonable efforts to maintain my Personal Health Information in a secure manner and not to disclose it to third parties without a legitimate reason for doing so. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits, including my access to therapy, is not conditioned on my signing this Authorization. I understand that I am entitled to a signed copy of this Authorization. This Authorization expires one year from the date of execution, or one year after the date of my last prescription, whichever is later. I understand that I may revoke this Authorization at any time by sending written notice of revocation to OnePath, 300 Shire Way, Lexington, MA 02421, which becomes effective upon receipt by any Health Care Provider subject to federal privacy laws, except to the extent that action already has been taken in reliance on this Authorization.

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

☐ I certify that all of the information provided on this form is complete and accurate. I authorize Shire to collect Personal Health Information from me, my caregivers, and Health Care Providers, and to use and disclose such Personal Health Information to provide product support services, including but not limited to coordination of benefits and therapy; reimbursement support; investigating insurance coverage; communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance.

(If patient is a minor)

Patient Signature | Parent/Guardian Signature

Date | Date

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ADDITIONAL GUIDANCE FOR COMPLETION OF FORM

1. Prescribing Physician Information
2. Patient Information
3. Insurance Information

- Fill out completely and fax form to OnePath
- Do not submit to Shire any documentation of labs, clinical history, or other documents supporting the prior authorization process

4. TAKHZYRO Prescription, Administration, and Prescribing Physician Signature

- Please check 1 option for dose—300 mg every 2 weeks or 300 mg every 4 weeks
- Remember to indicate the number of refills for your prescription
- Designate which injection supplies are needed with the TAKHZYRO shipments
- This is a prescription; a physician's signature and date are required

5. Patient Authorization to Share Personal Health Information and OnePath Enrollment

- The patient signature is required to allow personal health information to be given by third parties to Shire to facilitate access to TAKHZYRO (insurance benefits, self-administration training, transfer Rx to specialty pharmacy provider, etc)
- Checking the OnePath enrollment box allows patients to receive product support services from Shire, if eligible
  - Benefits investigation
  - Injection training (if applicable)
  - Co-pay support (when applicable) and information about third-party financial assistance programs, as necessary
  - Enrollment in OnePath—Patient Support Manager assignment and product support services

WHAT HAPPENS NEXT?

1. Once the completed form has been submitted to OnePath, a dedicated Patient Support Manager will be assigned to your eligible patient
2. The Patient Support Manager will contact the patient directly to inform him or her of the services available through OnePath and to begin the insurance verification process
3. The Patient Support Manager will work with the insurance company to determine insurance benefits
   - If applicable, OnePath will assess the patient's eligibility for co-pay support and any other means that will assist the patient in accessing TAKHZYRO
4. The Patient Support Manager will set up Shire-provided self-administration training services unless you have opted out of these services

INDICATION AND SELECT IMPORTANT SAFETY INFORMATION

TAKHZYRO is indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients ≥12 years of age. Hypersensitivity reactions have been observed. The most commonly observed adverse reactions were injection site reactions. Less common adverse reactions observed included elevated levels of transaminases. Safety and efficacy in pediatric patients <12 years of age have not been established.

For additional Important Safety Information, please see full Prescribing Information.

*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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Shire