ENTYVIO CONTRACT REQUEST FORM

Date ____________

Thank you for your interest in Takeda's Entyvio Purchase Program. The information on this request from will be used to determine if you are eligible for the program. If eligible, we will send an agreement to you with further instruction on how to proceed.

So that we can efficiently complete eligibility on your request, here are some helpful tips.

- Be sure to provide us with your Specialty Distributor account numbers. This ensures we are linking up your account correctly for contract pricing.
- We currently have 8 Authorized Specialty Distributors. When writing in your Specialty Distributors, choose from one of the following:
  - Amerisource Specialty Distribution
  - Besse Medical
  - Cardinal Health Specialty Distribution
  - CuraScript Inc. Specialty Distribution
  - FFF Enterprises
  - McKesson Specialty Health
  - McKesson Plasma and Biologics
  - Metro Medical
  - Oncology Supply
- All office locations are those locations that are doing infusions. If the location is not doing infusions, please do not include the location on the form.
- List only the physician who has a DEA linked to the Specialty Distributor account.

If you have any questions while filling out the form, please email entyvio.contracts@takeda.com.

ACCOUNT INFORMATION

Account Name ____________

Street Address ____________

City ____________ State ____________ Zip Code ____________

ACCOUNT CONTACT INFORMATION

Contact Name ____________ Contact Title ____________

Phone Number ____________ Email ____________

AUTHORIZED SPECIALTY DISTRIBUTORS

Distributor 1 ____________ Account Number ____________

Distributor 2 ____________ Account Number ____________

Distributor 3 ____________ Account Number ____________

OFFICE LOCATIONS

Office Name ______________________________
Address ______________________________
City ______________ State ________ Zip Code ______________
Facility HIN ______________ DEA Number ______________

Office Name ______________________________
Address ______________________________
City ______________ State ________ Zip Code ______________
Facility HIN ______________ DEA Number ______________

Office Name ______________________________
Address ______________________________
City ______________ State ________ Zip Code ______________
Facility HIN ______________ DEA Number ______________

Office Name ______________________________
Address ______________________________
City ______________ State ________ Zip Code ______________
Facility HIN ______________ DEA Number ______________

ASSOCIATED PHYSICIANS - if applicable

Physician Name ______________________ NPI ______________
Physician Name ______________________ NPI ______________
Physician Name ______________________ NPI ______________
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