

Patient Consent for Patient Information, Enrolling in Services, and Accessing Financial Support (referred to as “Patient Authorization”)

I hereby authorize my healthcare providers, my health insurance carriers, and my pharmacies to use and disclose my individually identifiable health information, including my medical records, insurance coverage information, and my name, address, and telephone number to Horizon Therapeutics USA, Inc. and its affiliates and their respective agents and representatives (collectively, “Horizon”), including third parties authorized by Horizon to administer drug support and to dispense drugs (collectively, “Horizon By Your Side”) for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with my healthcare providers and me about my treatment or condition and related products; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by Horizon By Your Side and/or Horizon, including nursing or patient access support services (government-reimbursed programs may not be eligible for all support services offered; please contact Horizon By Your Side for determination); and (6) to send me marketing information or offer me products and services related to my treatment or condition (or other products or services in which I might be interested) and to contact me occasionally to obtain my feedback (for market research purposes only) about my treatment, my condition, or my experience with Horizon and/or Horizon By Your Side otherwise as required or permitted by law. Further, I appoint the Program, on my behalf, to proceed with Program services and to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I understand the pharmacies may receive a fee from Horizon in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain health information pursuant to this Authorization.

I understand that Horizon, as well as my healthcare providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. I understand that I am entitled to a copy of this Authorization.

I understand that information disclosed pursuant to this Authorization in some cases may be redisclosed by the recipient and no longer protected by HIPAA or other privacy laws. But Horizon has agreed to use and disclose my information only for purposes of operating the program. I understand that I may cancel this Authorization at any time by mailing a signed letter requesting such cancellation to Horizon By Your Side, 1 Horizon Way, Deerfield, IL 60015, but that this cancellation will not apply to any information used or disclosed by my healthcare providers and/or health insurance carriers based on this Authorization before they are notified that I have cancelled it. Unless required by state law, this Authorization is valid for whichever is greater: (a) the duration of remaining on this treatment or (b) 10 years from the date signed below. A photocopy of this Authorization will be treated in the same manner as the original.

Date: _____

Patient’s Printed Name: _____

Patient’s/Legally Authorized Representative’s Signature: _____

Legally Authorized Representative’s Printed Name (if required): _____

Patient’s/Legally Authorized Representative’s Home Address:

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Patient’s/Legally Authorized Representative’s Telephone: _____ Home Mobile

Patient’s/Legally Authorized Representative’s Email Address: _____

Legally Authorized Representative’s Relationship to Patient: Spouse Parent/Legal Guardian Representative per Power of Attorney

Is there someone else with whom we may discuss your protected health information? No Yes

Name: _____

Relationship to you: _____

Name: _____

Relationship to you: _____