



Authorization to Use and Share Health Information

I authorize **PANTHERx Rare**, my healthcare provider, and their business associates as necessary to disclose my Protected Health Information (PHI), including PHI related to my insurance, medical condition, treatment, and prescription details to Otsuka and its affiliates, business partners, vendors, and other agents ("Otsuka") so they can provide me with patient support services ("Services") for which I am eligible. Once I authorize disclosure of my PHI, it may no longer be protected by federal health privacy law and applicable state laws.

My PHI includes:

- My name, address, date of birth, contact information, and insurance plan details
- Prescription, fulfillment, shipment, and other information provided by pharmacies or other sites of care
- Any additional information about me, my treatment and health conditions, as provided by my doctor in order to enroll me in Services

I understand and agree that Otsuka may combine PHI collected from me with information about me collected from other sources and use that combined information to administer the Services. Otsuka may tokenize, aggregate, and de-identify my PHI and combine that de-identified PHI with other information, as long as the combined data remains de-identified in accordance with HIPAA standards (i.e. an expert has opined that it cannot be used to identify me).

This HIPAA Authorization will expire 5 years after I sign it, unless I withdraw or cancel it sooner. If I cancel this HIPAA Authorization, I may no longer qualify for Services from Otsuka, but it will not impact my provider's treatment or my insurance benefits. I understand that this will not affect any uses or disclosures Otsuka has already acted in reliance on this authorization prior to the date this cancellation is received.

I understand that I do not have to sign this HIPAA Authorization to get my medication or insurance coverage, that I have a right to receive a copy, and that I can cancel this Authorization at any time by writing to **privacy@pantherxrare.com** or **PANTHERx Rare (Building Five), 121 Bayer Road, Pittsburgh, PA 15205**.

Patient Signature: _____

Date: _____

Patient Printed Name: _____



Patient Consent to Enroll in Services

I agree to enroll in the Otsuka Patient Services program and authorize Otsuka and its affiliates, business partners, vendors, and other agents (collectively "Otsuka") to provide me with the patient support services ("Services") for which I am eligible under this program. Such services may include but are not limited to the following:

- Help coordinate insurance coverage for, access to, and receipt of my medication
- Communicate with me about possible financial assistance and, if I am eligible, enroll and administer my participation in those programs
- Communicate with me about my medication, treatment, and disease, including reminders and other product-related information
- Ask for feedback related to the Services or my treatment experience

I hereby expressly consent to the processing of my sensitive health information by Otsuka as necessary to provide me with the Services. I understand that I do not need to enroll to receive treatment from my healthcare provider.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____