JazzCares
Making a difference in Patients' lives, one Patient at a time

JazzCares® Patient Authorization Form

*Indicates required field.

Patient Authorization and Request for Transmission of Personal Information to Jazz Pharmaceuticals

Signature is required for participation in Jazz-sponsored patient support programs and activities

*Prescriber Name	*Patient/Patient Representative	*Date of Birth

I hereby authorize and direct my prescriber(s) and their staff, my health insurer(s) and the specialty pharmacy that will fill my prescription (the "Pharmacy"), to disclose the following information ("Personal Information") to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together "Jazz Pharmaceuticals" or "Jazz") for any Jazz-sponsored patient support programs and activities, including the JazzCares program:

- Information concerning my treatment with Jazz Pharmaceuticals' products, including relevant diagnoses and prescriptions; and
- Information about my health insurance benefits, including deductibles and out-of-pocket costs.

I understand and authorize Jazz Pharmaceuticals to use and further disclose the Personal Information it receives as a result of this Form for the following purposes:

(i) operating, administering, enrolling me in, and/or continuing my participation in the JazzCares program or any other Jazz-affiliated patient support services and activities related to my condition or treatment;
(ii) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Jazz Pharmaceuticals' products;
(iii) coordinating my receipt of and payment for Jazz Pharmaceuticals' products;
(iv) contacting me about any Jazz-sponsored patient support programs and activities, including the JazzCares program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews);
(v) contacting and providing my Personal Information to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment;
(vi) de-identifying my Personal Information by aggregating it for research purposes;
(vii) managing Jazz-sponsored patient support programs and activities, including the JazzCares program, and administrative purposes that support these services and programs.

I understand and authorize Jazz Pharmaceuticals to contact me using the contact information provided to Jazz to enroll me in, operate, and administer any Jazz-sponsored patient support services, including the JazzCares program, through a variety of means including email, postal mail, phone, fax, or SMS/text (which I can separately opt in below) unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below. I understand that the operation and administration of certain of these services and/or programs may require that Jazz contact me by telephone or SMS/text.

Patient Authorization Form (cont.)

I understand Jazz Pharmaceuticals may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Personal Information about me that Jazz Pharmaceuticals may create or receive. I understand that my health insurer(s), Pharmacy, and third party vendor(s) may receive remuneration (payment) in exchange for disclosing my Personal Information to Jazz Pharmaceuticals (including JazzCares, its affiliates, and vendors who help provide the services) and/or for providing me with support services for the purposes described above.

I understand that after my Personal Information is transmitted to Jazz Pharmaceuticals, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). However, Jazz Pharmaceuticals will not disclose my Personal Information to a third party that is not related to the patient support programs (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my Personal Information, I understand the receiver may not be subject to HIPAA or other privacy laws and the Personal Information might be re-disclosed by the recipient.

I understand that I may refuse to sign this Form and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, my health insurer(s) and the Pharmacy, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. I also understand that I can revoke this Form at any time in the future, but if I do so, I may no longer be eligible to participate in Jazz-sponsored patient support programs and activities, including the JazzCares program.

I understand that should I revoke this Form, the revocation will not impact uses and disclosures of my Personal Information that have already occurred in reliance on this Form. This Form will remain valid until termination of enrollment in Jazz-sponsored patient support programs and activities, including the JazzCares program, unless a shorter time is required by state law. I can also revoke it earlier by calling 1-866-997-3688 or sending my request to: Jazz Pharmaceuticals, PO Box 66589, St. Louis, MO 63166-6589.

I understand the Program may be changed or ended at any time without prior notification. I understand I may request a copy of this Form that is on file with Jazz.

Further information concerning Jazz Pharmaceuticals' privacy practices can be found at https://www.jazzpharma.com/privacy-statement/. If you are a resident of California, a description of the personal information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found on this website: https://www. jazzpharma.com/privacy-statement/supplemental-notice-for-california-consumers/.

I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

***Patient/Patient Representative**	***Date**

US-OHD-2000207

Call JazzCares toll free at 1-833-533-5299, Monday-Friday, 8 am to 8 pm ET.

Fax completed forms to 1-855-593-3955.

Mail completed forms to JazzCares Program, PO Box 5490, Louisville, KY 40255.