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

Jazz Pharmaceuticals' Patient Authorization Form

Jazz Pharmaceuticals

Fax completed Form to 1-866-470-1744
For more information call 1-866-997-3688

Please Print

Prescriber Name ____

Patient Name ____________________________ **Date of Birth** ________________

Patient Authorization for Disclosure and Use of Health Information (SIGNATURE IS REQUIRED FOR PARTICIPATION in Jazz- sponsored patient support programs and activities)

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 my Health 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.

I consent to the collection, processing, and disclosure of my Health Information for the purposes described in the Patient Authorization Disclosure.

I confirm that I have read, understand, and accept the Patient Authorization Disclosure.

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.

I agree to the use of electronic records and signatures. I acknowledge that I will have the option to download this document after hitting the submit button and the ability to save or send this electronic record and disclosure to a location where I can print it, for future reference and access.

Patient/Guardian Signature ____

Email ____________________________________ **Date** ____________________

Consent to receive email communications from Jazz about educational programs, products, and services

☐ By checking this box, I confirm that I am 18 years of age or older and a resident of the U.S. I am indicating that I would like to receive information from Jazz about educational programs, products and services. I consent to the collection, processing and sharing of my Health Information, by Jazz, its affiliates and services providers to conduct marketing activities and to communicate with me regarding products and services that may be of interest to me. I understand that Jazz will not sell my Health Information to third parties.

I can unsubscribe at any time from future email communications from Jazz by clicking the "unsubscribe" link provided in email communications from Jazz Pharmaceuticals. I can withdraw consent from collection, use or sharing of my Health Information for marketing purposes at any time using one of the methods listed in the US Consumer Health Data Privacy (https://www.jazzpharma.com/us-consumer-health-data-privacy-policy).

Consent to telephone communications from Jazz (TCPA Consent)

☐ By checking this box, I consent to Jazz calling and texting me at the phone number(s) provided with promotional communications relating to Jazz products and services and/or my condition or treatment (standard text messaging rates may apply). I can reply STOP to opt out at any time.

Home Phone ________________________ **Cell Phone** ________________________

I understand that participation in Jazz-sponsored patient support programs and activities, including the JazzCares program, is voluntary, and, if I have consented, receipt of marketing communications are optional services.

The consent(s) above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications.

Patient Authorization Disclosure

I. Uses and Disclosure of Health Information

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 my name (and the name of my caregiver if applicable), gender, date of birth, contact information and the following information (together "Health Information") to Jazz Pharmaceuticals (including its affiliates and services providers acting as data processors) (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 my Health 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; coordinating my receipt of and payment for Jazz Pharmaceuticals' products;
(iii) 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);
(iv) contacting and providing my Health Information to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrolment;
(v) de-identifying my Health Information by aggregating it for research purposes;
(vi) managing Jazz-sponsored patient support programs and activities, including the JazzCares program, and administrative purposes that support these services and programs.

I understand Jazz Pharmaceuticals will not sell my Health Information to third parties, but Jazz Pharmaceuticals may disclose such information to its affiliates and services providers for the purpose described in this Form. I also understand that if I do not consent to the use of my Health Information for the above purposes, I will not be able to participate in Jazz-sponsored patient support programs and activities, including the JazzCares program.

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 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.

I understand Jazz Pharmaceuticals may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Health 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 Health Information to Jazz Pharmaceuticals (including JazzCares, its affiliates, and services providers acting as data processors) and/or for providing me with support services for the purposes described above.

I understand that after my Health 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 Health 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 Health Information, I understand the receiver may not be subject to HIPAA or other privacy laws and the Health Information might be re-disclosed by the recipient.

II. No Effect on Treatment.

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.

III. Expiration, Right to Obtain a Copy and Right to Revoke

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 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.

I also understand that I can withdraw my consent to the processing of my Health Information for the above purposes and revoke this Form at any time by calling 1-866-997-3688, emailing customercare@jazzpharma.com or sending my request to: Jazz Pharmaceuticals, PO Box 66589, St. Louis, MO 63166-6589. If I do so, I will 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 Health Information that have already occurred in reliance on this Form.

More information on Jazz Pharmaceutical's privacy practices

Further information concerning Jazz' 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 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/.