AVYXASSIST™

Visit us at www.avyxa.com

PATIENT CONSENT

Call us at **866-939-8927 Monday - Friday 8:00 AM - 8:00 PM (ET)**
Fax: 833-852-3420

*Required Field

First Name* ______________________ Last Name* ______________________

Parent/Legal Guardian Name ______________________ Relationship To Patient ______________________

Patient Date of Birth (mm/dd/yyyy)* ______________________ Patient's Gender* ______________________

Address* ______________________

City* ______________________ State* ______________________ Zip* ______________________

Email* ______________________ Preferred Phone Number* ______________________

Contact Preference:

◯ Phone ◯ Email

Best Time To Contact:

◯ AM (8am - 10am) ◯ Day (10am - 5pm) ◯ PM (after 5pm)

Patient Consent

I hereby authorize my healthcare providers (including pharmacy providers) and health plans to disclose my personal health information related to this prescription form or my use or potential use of AVYXA™ Product, including my personal contact information on this form (collectively, my "Information"), to the patient support program called AVYXASSIST™ (the "Program") so that the Program may use and disclose the Information in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my benefit and coverage status and my medical care; (3) provide support services, including facilitating the provision of AVYXA™ Product to me, as well as any information or materials related to such services or AVYXA™ products, including promotional or educational communications; (4) evaluate the effectiveness of AVYXA™ Product support programs; (5) report safety information, including in communications with the US Food and Drug Administration and other government authorities; (6) contact me regarding this prescription form or my use or potential use of AVYXA™ Product and provide me with related patient support communications, including through messages left for me that disclose that I take or may take AVYXA™ Product; and (7) allow AVYXA™ to analyze the usage patterns and the effectiveness of AVYXA™ products, services, and programs and help develop new products, services, and programs, and for other AVYXA™ general business and administrative purposes. I understand that my provider(s) may receive remuneration in exchange for the provision of my Information as authorized above, and that once my Information has been disclosed to the Program, federal privacy law may no longer restrict its use or disclosure and that it may be redisclosed to others. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law. I understand that if I refuse to sign this Authorization, that will not affect my right to treatment or payment benefits for health care. If I qualify for and receive free medication from the "Program", I agree to comply with the Program's rules; and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that the "Program" help is temporary, I must reapply every year, and I may not be eligible if I have prescription drug coverage that will pay for my medication. To the best of my knowledge, (1) My insurance plan did not require me to apply to the Program and/or change or hide my insurance coverage to make me appear to be underinsured and eligible for the "Program"; (2) The Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company or the insurance company's business partners. I agree to immediately contact the "Program" at 866-939-8927 if my insurance, treatment, or financial situation changes in any way. I understand that the AVYXASSIST™ programs may be discontinued or the rules for participation may change at any time, without notice. Consent to credit check (for Free Product Assistance Only) I also understand that AVYXASSIST™ may request documentation from me, my employer, my healthcare provider, or my insurance company to verify my financial information. AVYXA™ may obtain information from my credit profile from Experian Income View for the purpose of verifying my income eligibility for AVYXASSIST™. I understand that I am providing "written instructions" to AVYXA™, under the Fair Credit Reporting Act ("FCRA"), authorizing AVYXA™ to obtain information from my credit profile or other information from Experian Income View solely for the purpose of determining financial qualifications for AVYXASSIST™ and on an ongoing basis as needed for the duration of my participation in AVYXASSIST™. I understand that I am entitled to a copy of this Authorization upon request. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to AVYXASSIST™, 13410 Easpoint Centre Drive, Louisville, KY 40223, and that such withdrawal will not affect any uses and disclosures of my Information prior to the Program's receipt of the notice. I am entitled to a copy of this signed Authorization, which expires 10 years from the date it is signed by me or such timeframe as allowed by law. Please note documentation proving Power of Attorney may be required.

◯ By signing below, Patient/Parent/Legal Guardian indicates that they have read (or been read) the Patient Consent and agree.

Patient/Parent/Legal Guardian Signature

First Name* ______________________ Last Name* ______________________

Signature* ______________________ Date of Signature (mm/dd/yyyy)* ______________________

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