MyRYTARY® Patient Support Program
PATIENT AUTHORIZATION FORM

Please complete all fields with black ink and fax form to 1-844-IMPAX08.

For help, please call 1-844-IMPAX2U.

PATIENT INFORMATION

Name: (First) _____ (Last) _____

Address: _____

Home Phone: (_____)_____-_____ Mobile Phone: (_____)_____-_____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

DOB: (mm/dd/yyyy) ____/____/_____ Gender: ☐ Male ☐ Female

City: _____ State: _____ ZIP Code: _____

Email: _____

Are you a United States resident? ☐ Yes ☐ No

If you are unavailable when we call, may we leave a message including the prescription name? ☐ Yes ☐ No

PATIENT INSURANCE INFORMATION

If the patient has Medicare, please check all that apply: ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage

☐ Secondary/Supplemental ☐ Veterans Affairs Benefits ☐ State Pharmaceutical Assistance Program

Medical Insurance Company: _____

Name of Insured (Cardholder) : _____

Policy #: _____ Group # : _____

Member ID #: _____ Plan Phone: (_____)_____-_____

Prescription Drug Plan Name: _____

Name of Insured (Cardholder): _____

BIN #: _____ PCN # : _____

Policy #: _____ Group # : _____

Plan Phone: (_____)_____-_____

Please copy the front and back of medical insurance and prescription drug plan cards and include with fax.

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I understand that I am submitting this application to TrialCard, or my doctor's office is submitting it on my behalf, to see if I qualify for financial assistance and other services to help me find possible sources of financial assistance, or to assess whether I have insurance coverage for RYTARY®. I understand that before you can assist me, you may need to collect, use, and disclose information about me that is requested on this application, including my Protected Health Information ("PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA")), my financial information and other personal information about me (collectively "My Personal Information"). PHI that will be disclosed includes any information related to my healthcare insurance or plan benefits, including coverage limits and other information related to my health.

I understand that by signing this form, I am permitting my doctor's office, my healthcare plan or insurance company, my pharmacies, as well as other entities that may hold my PHI, to release My Personal Information, including my PHI, to TrialCard and to TrialCard's agents who may be assisting with the administration of the patient assistance programs. I understand that to provide the services for the patient assistance programs, TrialCard and the TrialCard Agents may need to further disclose My Personal Information to and communicate with other TrialCard Agents involved with patient assistance programs, my doctor's office or other health care providers, including my insurance company or health plan or pharmacies.

I further understand that TrialCard and the TrialCard Agents will use My Personal Information in the following manner: (1) to review my application for patient assistance programs; (2) to help determine my healthcare plan coverage for RYTARY® and other procedures as part of my therapy by conducting reimbursement verification and obtaining payment from my Health Plan(s); (3) to contact me or my doctor's office or other of my health care providers, as necessary, to conduct such services; and (4) providing me with educational support services by mail, text, messaging, email and/or telephone and (5) referring me to, or determining my eligibility for, other programs, foundations or alternative sources of funding or coverage to help me with the cost of RYTARY®.

I understand that I do not have to sign this consent, but if I do not, the MyRYTARY® Patient Support Program cannot provide the described services. I understand that I might need to pay for RYTARY® on my own, whether I sign this form or not. I understand that once my doctors, healthcare plan, pharmacies, or others who have my Protected Health Information release it, my information may no longer be covered by Federal Privacy Law (for example, HIPAA).

This authorization allows those who rely on it to release my Protected Health Information for 10 years from the date I have signed it. I understand that I can withdraw it at any time by sending a written request to the mailing address below. My withdrawal goes into effect once it is received by the program. I also understand that by withdrawing, I may not receive or I may stop receiving the services provided under this program.

Patient's Signature: _____ Date of Signature: _____/_____/_____

Printed Name: _____

Parent/Guardian/Legal Representative's Signature: _____ Date of Signature: _____/_____/_____

Printed Name: _____ Relationship to Patient: _____

PATIENT AUTHORIZATION TO DISCLOSE TO OTHERS

In order to protect your privacy we will not share your information with anyone you do not authorize. Please list names of anyone you would like to have access to your medical information. Only the names listed below will be given any information regarding your medical condition.

I hereby authorize TrialCard, its staff and providers to disclose my protected health information to the following representative:

Name: _____ Phone Number: (_____)_____-_____

Relationship to Patient: _____

Patient's Signature: _____ Date of Signature: _____/_____/_____