



833-NSSUPRT (833-677-8778)

Patient Authorization Form for VILTEPSO® (viltolarsen)

FAX OR MAIL THE COMPLETED FORM TO NS SUPPORT



888-212-0482



PO Box 7613, Overland Park, KS 66207-9941

PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE AUTHORIZATION ON BEHALF OF PATIENT

Permission to share and use Protected Health Information

My (or my parent/guardian/legal representative's) signature below authorizes each of my physicians and pharmacists (including any specialty pharmacies and other healthcare providers) and each of my health insurers to use and disclose my Protected Health Information ("PHI"), including but not limited to medical records, information related to my medical condition and treatment, financial information, lab values, insurance coverage information, my name, address, and telephone number, to NS Pharma, Inc., and its Patient Engagement Leads, agents, contractors, and assignees (together, "NS Pharma") to enroll me in and contact me (or my parent/guardian/legal representative) about NS Support; provide case management by mail, email, phone calls, detailed voice messages, interactive voice recordings that may include use of auto-dialers or artificial or prerecorded voice messages, and SMS text messages (data rates may apply) as explained in the Telephone Consumer Protection Act (TCPA) consent to assist with adherence to my medication regimen; and work with third parties to provide community resources and referrals. Third-party vendors, such as specialty pharmacies, may receive financial remuneration in exchange for data, product support services, reimbursement services, etc. This authorization expires 5 years from the date of execution, unless a shorter period is required by state law. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may refuse to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits, including my access to therapy, is not conditioned on signing this authorization. I (or my parent/guardian/legal representative) understand that revoking this authorization will not affect the ability to use and disclose PHI received prior to receipt of notification that I (or my parent/guardian/legal representative) wish to discontinue my participation in the program. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may revoke this authorization at any time verbally at 833-NSSUPRT (833-677-8778) or in writing to NS Support at PO Box 7613, Overland Park, KS 66207-9941. Once authorization has been revoked or expired, I (or my parent/guardian/legal representative) understand that my future PHI will not be disclosed. I (or my parent/guardian/legal representative) understand that my PHI will not be used or disclosed for any other purposes, unless permitted by law, than for the purposes stated above. Information disclosed pursuant to this authorization or provided to a third party may no longer be protected by federal privacy laws. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) have a right to receive a copy of this authorization.

Cancelling this authorization

A copy of this authorization will be as valid as the original. Cancelling this authorization will not affect the ability of NS Pharma to use and disclose Protected Health Information that it has received prior to receipt of the cancellation of my (or my parent/guardian/legal representative's) authorization. My (or my parent/guardian/legal representative's) authorization will also end if NS Support is discontinued. Furthermore, I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) have the right to see or copy the Protected Health Information the patient's Healthcare Providers or Insurers have given to NS Pharma.

Communications consent

By checking the box below, I authorize NS Pharma to send promotional and/or educational patient communications related to my condition, treatment, or related products or services that might be of interest; to contact me (or my parent/guardian/legal representative) occasionally to obtain feedback for market research purposes about my treatment, condition, or experience with the product, NS Pharma, and/or NS Support; and to contact me (or my parent/guardian/legal representative) about other products and services offered by NS Pharma.

PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE AUTHORIZATION

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient/Parent/Guardian/Legal Representative Authorization above, for the patient to participate in the NS Support Program, and to release the patient's Protected Health Information to NS Pharma, Inc., supporting the access program as indicated on this form.

Promotional/educational communications consent: Yes, NS Pharma may send me promotional and/or educational patient communications related to my treatment and condition. Examples of these communications may include, but are not limited to, product information, newsletters, announcements, healthcare reminders, and tips. I understand that I (or my parent/guardian/legal representative) may opt out of receiving these communications at any time by following the instructions on the communications.

PATIENT NAME _____ DOB (MM/DD/YYYY) _____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE/PATIENT (IF OVER 18) SIGNATURE _____ DATE _____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE/PATIENT (IF OVER 18) PRINT NAME _____

RELATIONSHIP TO PATIENT _____

Questions? Call NS Support at 833-NSSUPRT (833-677-8778), Monday–Friday, 8 AM–8 PM ET.

