HORIZON UCD SUPPORT SERVICES

PATIENT AUTHORIZATION FORM INSTRUCTIONS

The UCD Support Services Patient Authorization Form gives Horizon Pharma and the Horizon UCD Support Services team the ability to provide support for patients on Horizon UCD Medications. The services include prescription management, support in securing reimbursement, referrals to patient financial support programs, drug shipment and refills outreach, and no-cost medication to qualified patients prescribed Horizon UCD Medications.

Instructions:

1. Fill out the patient's full name and date of birth.
2. Read and sign the HIPAA Authorization. If applicable, fill out the Personal Representative's full name and relationship to the patient.
3. Read and sign the Patient Consent & Program Services Opt-In and check the Additional Opt-In if desired. If applicable, fill out the Personal Representative's full name and relationship to the patient.
4. Fax the completed form to UCD Support Services at 877-695-8304. The form may also be mailed to Horizon UCD Support Services at

   7420 Goodlett Farms Parkway, Ste 110, Cordova, TN 38016.
5. For any questions about completing this form, the HIPAA Authorization, or the Patient Consent & Program Services Opt-In, please contact UCD Support Services at 855-UCD-SUPT (855-823-7878).

HORIZON PHARMA

HORIZON UCD SUPPORT SERVICES

Phone: 855-UCD-SUPT (855-823-7878) **Fax:** 877-695-8304
www.ucdsupport.com

UCD SUPPORT SERVICES PATIENT AUTHORIZATION

Please fax the completed form to 877-695-8304. **Please return with the UCD Support Services Prescription Form or PAP Application.**

Patient Name: _____ **DOB:** ____/____/____

Please sign both the HIPAA Authorization and Patient Consent & Program Opt-In Sections before returning.

HIPAA Authorization

The Horizon UCD Support Services program (the "Program") provides services which vary from patient to patient, and may include prescription management, support in securing reimbursement, referrals to patient financial support programs, drug shipment and refills outreach, compliance and persistency messaging to the patient and the patient's physician, and no-cost medication to qualified patients prescribed Horizon UCD Medications. This Authorization will allow the patient's health care provider(s) and health insurer(s) to share information with Horizon Pharma plc and companies working on its behalf, so that Horizon can provide the patient with the services described above for which the patient is eligible.

AUTHORIZATION: By signing this Authorization, I (the patient or the patient's personal representative) authorize each of my physicians, pharmacists, and other health care providers (collectively, "Health Care Providers") and each of my health insurers (collectively, "Insurers"), to use and/or disclose the protected health information described below to Horizon and its employees, including field representatives, and its agents (collectively, "Horizon") solely for the use of delivering Program services specific to me/my child. My health information may be disclosed orally or in writing, or through data transfer, facsimile, or email.

My Health Care Providers and Insurers may use or disclose my protected health information as requested by Horizon. This information may include: **(1)** my name, birth date, address, telephone number; **(2)** medical records and treatment information as necessary; **(3)** information about my health benefits or health insurance coverage; **(4)** and financial information about me. Horizon may receive and use this information to administer the Program as well as determine my eligibility for specific services such as financial assistance.

I understand that, once my protected health information has been disclosed to Horizon, federal privacy laws may no longer protect the information from further disclosure, but Horizon has agreed to use and disclose my information only for purposes of providing Program services. I also understand that:

- I do not have to sign this Authorization. My treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected. If I do not sign, however, I will not be eligible to receive Program services.
- This Authorization will remain in effect until I am no longer participating in the Program, at which time it will expire.
- I may revoke (cancel) this Authorization at any time by contacting UCD Support Services at 855-823-7878. If I cancel, my Health Care Providers and Insurers will not make further disclosures of my protected health information to Horizon; however, the cancellation will not affect Horizon's ability to use or disclose information it has already received. If I cancel, I will no longer be able to receive Program services.
- I am entitled to a copy of this signed Authorization.

Patient/Personal Representative Signature*: _____ **Date:** _____

Patient/Personal Representative Printed Name: _____

Relationship (Personal Representative), if applicable (parent, power of attorney, etc): _____

Patient Consent & Program Services Opt-In

By signing below, I agree to let the Horizon UCD Support Services program (the "Program") contact me by phone, mail, or email to provide more information about taking part in the Program, which provides services including prescription management, support in securing reimbursement, referrals to financial patient support programs, drug shipment and refill outreach, compliance and persistency messaging to the patient and the patient's physician, and no-cost medication to qualified UCD patients.

I further agree to allow Horizon to use and disclose information provided about me to deliver Program services requested by me or my physician. My information may be used and disclosed to administer the Program services described above. I authorize the Program to send, via mail or fax, prescription information to a pharmacy. I also understand and agree that:

- Horizon may verify the accuracy of the information on this form and request additional financial and insurance information.
- Horizon's privacy practices may change over time. Significant changes will be communicated in a timely manner to all participants of the Program.
- Horizon may change or discontinue the Program at any time. Significant changes will be communicated in a timely manner to all participants of the Program.
- This consent will be in effect for as long as I participate in the Program.
- I do not have to sign this consent, and I may revoke (cancel) it at any time by contacting UCD Support Services at 855-823-7878. If I revoke or do not sign the consent, I will not be eligible to receive Program services. Revoking or not signing the consent will not otherwise affect my treatment or insurance eligibility or benefits.
- I have given a signed HIPAA authorization form to my Health Care Provider.
- I will contact the Program if my financial status or insurance coverage changes.

☐ **Additional Opt-In:** I further authorize the Program to contact me about additional UCD patient support services such as patient education and medication compliance support. I understand I do not need to agree to this Additional Opt-In to be eligible to receive the Program services outlined above.

Patient/Personal Representative Signature*: _____ **Date:** _____

Patient/Personal Representative Printed Name: _____

Relationship (Personal Representative), if applicable (parent, power of attorney, etc): _____

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