octapharma
For the safe and optimal use of human proteins

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Octapharma Wilate Bridge Program

Patient Consent and HIPAA Authorization

Covance is operating the Octapharma Wilate Bridge Program and providing services on behalf of Octapharma, in accordance with all applicable HIPAA requirements. I authorize Covance to contact my healthcare provider, in order to release and disclose to such parties all relevant medical records, insurance and third-party payor information, and to send my Wilate® von Willebrand Factor/Coagulation Factor VIII (Human) prescription, via mail, fax or other mode of delivery, to the specialty pharmacy designated by Covance in order to facilitate dispensing of Wilate® to me. I also authorize my health- care provider to release and disclose to Covance such health information as is necessary to fulfill the above listed purposes. I understand that once information is disclosed it may no longer be protected by federal health information privacy laws and it is possible it may be re-disclosed.

This authorization will expire in five (5) years. I understand that my participation in the Octapharma Wilate® Bridge Program and related programs is entirely voluntary and I can withdraw my participation and/or revoke this authorization at any time by notifying Covance by fax to 800-554-6744 or by mail to 9801 Washington Blvd, 9th Floor, Gaithersburg, MD 20878. I also understand that, if I do not sign this authorization or if I revoke it, my healthcare provider will still treat me for my condition and I will still be eligible to receive Wilate®; however, I will not be eligible for enrollment in the Octapharma Wilate® Bridge Program and I may not receive the patient support services provided by the program.

☐ Check here if you would like to receive educational and therapy support services for patients taking Wilate® sponsored by Octapharma. Please note that, by checking this box, you are giving Covance and Octapharma permission to send you educational materials and to contact you about support programs for patients taking Wilate®, and for purposes of market research.

Patient/Applicant's signature _____Date_____

Relationship (if other than patient) _____