PATIENT AUTHORIZATION FOR BRILINTA PATIENT SUPPORT SERVICE

I authorize my health care provider, _____, to submit my patient information to BRILINTA Patient Support Service for the purpose of assisting my health care provider in verifying my prescription insurance benefits for prescriptions for BRILINTA® (ticagrelor) tablets and/or initiating coverage determination requests. This information may include, but it is not limited to, my name, date of birth, gender, address and contact information, my medical condition, my prescription information, my health insurance information, and/or relevant financial information. This information is considered Protected Health Information ("PHI") under the HIPAA Privacy Rule, located at 45 CFR Part 160 and Subparts A and E of Part 164, and may also be protected under state and local law.

Once my PHI is submitted to BRILINTA Patient Support Service, I understand that it will be used to verify my prescription insurance benefits and/or initiate coverage determinations, and may be shared with related physician or pharmacy staff involved in my care. I understand that, once my information is disclosed to BRILINTA Patient Support Service, it will no longer be protected by the HIPAA Privacy Rule, but it may be protected by state and local law. In addition, BRILINTA Patient Support Service has agreed to use and disclose my information only to the extent necessary to verify prescription insurance benefits and/or initiate coverage determinations, and will not otherwise disclose my information to those not involved in my care.

This authorization will be effective until one year from date of signature, or until I notify my provider that I no longer want my information to be disclosed to BRILINTA Patient Support Service. I understand that I can revoke this authorization by calling BRILINTA Patient Support Service at 1-888-51-BRILINTA (1-888-512-7454). I understand that, if I revoke this authorization, no further information will be disclosed by my health care provider, but my revocation will not affect any information that my health care provider has already disclosed in reliance on this authorization.

I understand that I can revoke this authorization at any time, that I am not required to sign this form, and that my health care provider cannot condition treatment or eligibility for benefits on my execution of this authorization. I also understand that I have a right to receive a copy of this form and to inspect or copy the PHI that is to be used and disclosed by my health care provider pursuant to this authorization.

PATIENT NAME	
SIGNATURE	
DATE	
If caregiver, describe relationship to patient and your signing rights on behalf of patient	

This voluntary authorization form may be modified for use by health care providers who wish to supplement their existing consent program with specific patient consent in regards to the use of BRILINTA Patient Support Service in the course of the patient's care. Providers should ensure that their consent program meets all applicable local, state, and federal regulations.

Please read accompanying full Prescribing Information, including Boxed WARNINGS, and Medication Guide.

BRILINTA® ticagrelor tablets

AstraZeneca