Exservan (riluzole) oral film

Patient Authorization Form for EXSERVAN™ (riluzole) oral film

INSTRUCTIONS

- **If the patient has not already signed a Prescription and Enrollment Form for EXSERVAN™, the patient must read this Patient Authorization and sign on the following page to authorize PANTHERx Rare Pharmacy (PANTHERx) services.**
- **Patient should retain a copy of this form for their records.**

PATIENT AUTHORIZATION

My signature on page 2 serves as confirmation that I authorize each of my physicians and pharmacists, including PANTHERx Rare Pharmacy (PANTHERx) which receives my prescription for EXSERVAN™ (riluzole) oral film and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to use and disclose my Protected Health Information, including, but not limited to, medical records and history, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, insurance plan and/or group numbers (together, "Protected Health Information") to Mitsubishi Tanabe Pharma America, Inc., its affiliated companies, agents and representatives (together, "Mitsubishi Tanabe Pharma America" or "MTPA"), including vendors providing relevant patient education programs and other service providers supporting product access programs for Healthcare Providers and patients for the purposes described below ("product access services").

PRODUCT ACCESS SERVICES ENROLLMENT

I specifically authorize MTPA to receive, use, and disclose my Protected Health Information for the following purposes: (i) to enroll me in, and contact me and/or the person legally authorized to sign on my behalf, about product access services, including potential enrollment in the Out-of-Pocket Assistance Program for EXSERVAN™ if I am an eligible, commercially insured patient with insurance coverage for EXSERVAN™; (ii) to provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to EXSERVAN™ and to contact me about enrolling in a relevant patient education program; (iii) to provide access support education, including contacting my Healthcare Providers regarding my coverage for EXSERVAN™; (iv) to assist with analyses related to the quality, efficacy, and safety of EXSERVAN™ and patient access to and treatment compliance with EXSERVAN™; and (v) to enhance and improve the product access services. MTPA may use my Protected Health Information to contact me for any of these purposes by mail, email, and telephone. To opt out of receiving future communications about product access services, I may call PANTHERx at 1-855-743-9275 or follow the instructions in any communication I receive. I understand that if I opt out from receiving communications, I will no longer be able to participate in or receive assistance from the Out-of-Pocket Assistance Program for EXSERVAN™.

MARKETING COMMUNICATIONS AND MARKET RESEARCH OPT-IN

Checking the box below my signature on page 2 serves as confirmation that I authorize MTPA to receive, use, and disclose my Protected Health Information for the following purposes: (i) to send me marketing information related to my condition, my treatment, or related products or services that might be of interest to me; (ii) to contact me occasionally to obtain my feedback for market research purposes about my treatment, my condition, or my experience with EXSERVAN™ and/or MTPA; and (iii) to contact me about other products and services offered by MTPA. MTPA may contact me for these purposes by mail, email, and telephone. If I check the YES box on page 2, MTPA may contact me for these purposes using SMS text messages. Marketing communications will include information about how I can opt-out of receiving future communications. I understand that my receipt of product access services will not be affected if I choose not to opt-in or if I later opt-out of marketing communications.

GENERAL INFORMATION

I understand that the pharmacy that ships my medication may be paid to share information with PANTHERx in order to help provide the offerings requested for me. I also understand that my Protected Health Information will not be used or disclosed by MTPA for any other purpose than described in this Form without my authorization unless permitted by law or unless information that specifically identifies me is removed so that the information is "de-identified." I understand that MTPA will make every effort to keep my information private. I understand that information used or disclosed under this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law. For additional information on how MTPA collects, uses, and discloses personal information, I can visit mt-pharma-america.com/privacy-policy. I understand that I am not required to sign this Patient Authorization for EXSERVAN™. My decision whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I do not sign the Authorization on page 2, or cancel (revoke) my Authorization later, I understand that this means I will not be able to receive product access services. However, I understand I may call PANTHERx to request assistance at any time. I also understand I may receive a summary of my health insurance benefits, which may be sent to me following a benefits investigation even though I did not sign this Patient Authorization. This Authorization will remain in effect for 5 years from the date of my signature, or until I am no longer receiving product access services, whichever is sooner. A copy of this Authorization will be as valid as the original. I may cancel this Authorization at any time in writing by mailing a letter to PANTHERx Rare Pharmacy, 24 Summit Park Drive, Pittsburgh, PA 15275. I can also cancel my Authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with MTPA. Cancelling this Authorization will not affect the ability of MTPA to use and disclose Protected Health Information that it has received prior to receipt of the cancellation of my Authorization. My Authorization will also end if product access services for EXSERVAN™ are discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to MTPA.

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PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last, Suffix) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ DOB (MM/DD/YYYY) _____ GENDER ☐ M ☐ F

HOME PHONE _____ MOBILE PHONE _____ PREFERRED NUMBER TO CALL ☐ Home Phone ☐ Mobile Phone

ADDITIONAL CONTACT NAME _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____ MOBILE PHONE _____ PREFERRED NUMBER TO CALL ☐ Home Phone ☐ Mobile Phone

MARKETING COMMUNICATIONS AND MARKET RESEARCH TEXT MESSAGE OPT-IN

☐ YES - I agree to receive updates and information about ALS and treatment options from JourneyMate by SMS text messages. Message frequency varies. Text HELP to 85427 for help. Text STOP to 85427 to end. Message and data rates may apply. By opting in, I authorize JourneyMate to deliver SMS text messages using an automatic telephone dialing system and I understand that I am not required to opt-in as a condition of purchasing any property, goods, or services. Read Text Message Terms and Conditions (exservan.com/mobile) and Privacy Policy (exservan.com/privacy-policy).

☐ NO - I do not agree to receive marketing communications via SMS text messages as described above.

PATIENT AUTHORIZATION (Patient must read the Patient Authorization and sign below.)

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient Authorization included on page 1, to receive product access services and to release my Protected Health Information to Mitsubishi Tanabe Pharma America (as defined), for the purposes described in this Authorization.

PATIENT SIGNATURE _____ DATE _____

☐ By checking this box, I agree that my Protected Health Information can be used and disclosed for the marketing communications and market research purposes described on page 1.

If patient cannot sign above, patient's Legal Representative must sign below.

PATIENT NAME (Please Print) _____

LEGAL REPRESENTATIVE NAME (Please Print) _____

NATURE OF RELATIONSHIP TO PATIENT _____

By signing on this line, I certify under penalty of perjury that I am the legally authorized representative with authority to sign on behalf of the patient named herein.

LEGAL REPRESENTATIVE SIGNATURE _____ DATE _____

WITNESS NAME (Optional) (Please Print) _____

WITNESS SIGNATURE _____ ☐ NOTARY

FAX COMPLETED FORM TO 1-855-905-5938.

Please see full Prescribing Information, including Patient Important Safety Information (ISI) for EXSERVAN™, available at exservan.com.

Mitsubishi Tanabe Pharma America

Mitsubishi Tanabe Pharma America, Inc.
525 Washington Blvd., Suite 400
Jersey City, NJ 07310