SYNAGIS Parent/Caregiver Consent Form

SYNAGIS CONNECT™ is a patient support program created by Sobi to provide individualized support to help appropriate patients get access to SYNAGIS® (palivizumab). SYNAGIS CONNECT™ can help parents and caregivers understand the treatment process and their financial options, support providers in navigating insurance and reimbursement questions, and assist in the coordination of care and the specialty pharmacy process.

In order for the patient and their caregiver to take advantage of this program, consent/authorization must be obtained.

Parent/caregiver should complete this form legibly and sign it. All completed forms should be faxed to 1-800-201-4938.

PATIENT INFORMATION

Last Name:______________________ First Name:______________________ Middle Initial: __________

Date of Birth:______________________ SYNAGIS CONNECT™ Hub ID (if known): ______________________

PARENT/CAREGIVER INFORMATION

Last Name:______________________ First Name: ______________________ Middle Initial:__________

Street: ______________________ Unit: ________ City: ______________ State: ________ ZIP Code:__________

Home Phone #:______________________ Mobile Phone #:______________________

Email: ______________________ Preferred Contact Method: ○ Phone ○ Text ○ Email

Best Time to Call: ○ Morning ○ Afternoon ○ Evening Preferred Language: ______________________

○ I authorize **SYNAGIS CONNECT™** to send text messages when appropriate and hereby agree to receive this type of communication. Standard data and message rates may apply.

○ I authorize **SYNAGIS CONNECT™** to leave a detailed message, including the name of my child's prescription, SYNAGIS.

○ **Enroll me in the SYNAGIS Copay Program.** Eligibility requirements apply.

PRESCRIBER INFORMATION

Primary Care Provider/Specialist Name:____

Street: ______________________ Suite: ________ City: ______________ State:________ ZIP Code:__________

Phone #:______________________ Fax #:______________________

AUTHORIZATION TO SHARE HEALTH INFORMATION:

By signing below, I authorize my child's healthcare providers and staff, pharmacies, and health insurers to use and to disclose to Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "Sobi") health information about my child related to my child's medical condition and treatment, health insurance and coverage claims, and prescription (including fill/refill information) for SYNAGIS ("Information") to (1) enroll my child in and provide services under the SYNAGIS CONNECT™ patient support program (the "Program"); (2) obtain information on my child's insurance coverage; (3) coordinate prescription fulfillment as indicated by my child's physician; (4) provide me with adherence reminders and support; and (5) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Sobi support programs or Sobi products. Once my child's Information has been disclosed to Sobi, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Sobi will protect my child's Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise required by law.

I understand and agree that the pharmacy that dispenses SYNAGIS may receive payment from Sobi in exchange for disclosing my child's Information to Sobi and providing Program services.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my child's ability to obtain medical treatment from healthcare providers, payment for treatment or eligibility for health insurance benefits, or access to Sobi medications. However, if I do not sign this Authorization, I understand my child will not be able to participate in the Program.

I understand that this Authorization expires ten years from the date signed below, or earlier if required by state or local law, unless and until I cancel (take back) this Authorization before then. I may change my mind and cancel this Authorization at any time by calling 1-833-SYNAGIS (1-833-796-2447) or by notifying Sobi in writing at SYNAGIS CONNECT, PO Box 29076, Phoenix, AZ 85038-9076. Cancellation of this Authorization will end further uses and disclosures of my child's Information by my child's healthcare provider and staff, pharmacies, and health insurers based on this Authorization, and my child's participation in the Program when they receive notice of my cancellation, but will not affect any uses or disclosure of my child's Information made by my child's healthcare providers and staff, pharmacies, and health insurers based on this Authorization before receipt of the cancellation.

Full name (printed) of parent/caregiver ____

SIGN HERE **Signature of Parent/Caregiver** ______________________ **Date**______________________

CONSENT FOR ENROLLMENT IN SYNAGIS CONNECT™:

By signing below, I am enrolling in SYNAGIS CONNECT™ (the "Program"). I authorize Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Sobi, Inc., "Sobi") to provide me and my child with services for which we are eligible under the Program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to enrollment in the copay assistance program if I am eligible.

○ I also consent to receive autodialed and prerecorded marketing calls and text messages from Sobi, and companies working with Sobi, at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from Sobi. I understand that I may revoke this Authorization and choose not to receive automated marketing calls and text messages from Sobi at any time by calling 1-833-SYNAGIS (1-833-796-2447) or by notifying Sobi in writing at PO Box 29076, Phoenix, AZ 85038-9076.

Full name (printed) of parent/caregiver ____

SIGN HERE **Signature of Parent/Caregiver** ______________________ **Date**______________________

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