SYNAGIS CONNECT®

# Parent/Caregiver Consent Form

- Call SYNAGIS CONNECT at **1-833-SYNAGIS (1-833-796-2447)** Monday through Friday 8 AM to 8 PM ET, or visit **Synagis.com**
- Fax completed form to SYNAGIS CONNECT at **1-800-201-4938**

**SYNAGIS CONNECT™ offers access and reimbursement support to help patients access SYNAGIS® (palivizumab). SYNAGIS CONNECT provides information regarding patient insurance coverage and financial assistance information that may be available to help patients with financial needs. SYNAGIS CONNECT can:**

- **Evaluate a patient's insurance coverage, including benefits investigation, prior authorization, and appeal support**
- **Identify potential financial assistance options that may be available to help patients with financial needs**
- **Answer logistical questions and provide information and coordination around the specialty pharmacy fulfillment process**

## PATIENT INFORMATION

*Asterisk indicates required field.

Last Name*: _____ First Name*: _____ Middle Initial: _____

Date of Birth*: _____

## PARENT/CAREGIVER INFORMATION

Last Name*: _____ First Name*: _____ Middle Initial: _____

Street*: _____ Unit: _____ City*: _____ State*: _____ ZIP Code*: _____

Home Phone*: _____ Mobile Phone: _____

Email: _____ Preferred Contact Method: ○ Phone ○ Email

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

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

## PRESCRIBER INFORMATION

Primary Care Provider/Specialist Name*: _____

Street*: _____ Suite: _____ City*: _____ State*: ____ ZIP Code*: _____

Phone*: _____ Fax: _____

## AUTHORIZATION TO SHARE HEALTH INFORMATION

**My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement on page 2.**

*SIGN HERE* **Patient Signature:** _____ **Date:** ____/____/____

**OR**

*SIGN HERE* **Parent/Authorized Representative Signature:** _____ **Date:** ____/____/____

I am signing on behalf of the patient, and I affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have a valid power of attorney to act on behalf of the patient.

SYNAGIS CONNECT®

Patient Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____

## PATIENT AUTHORIZATION STATEMENT

My signature below on this enrollment form authorizes my child's doctor(s), healthcare providers, health plan or payer, and pharmacy to disclose to Sobi Inc. ("Company") and its third party suppliers, vendors, and other service providers supporting SYNAGIS CONNECT® (collectively, the "Service Providers") information about my child including my child's medical condition and treatment, health insurance and coverage claims, and prescriptions (together, "Protected Health Information and/or Personally Identifiable Information"). This information can include spoken or written facts about my child's health and insurance benefits. It can include copies of records from my child's healthcare providers or health plans about my child's health or healthcare. I understand that my child's healthcare providers and my child's pharmacy may receive remuneration, or payment, for disclosing my child's information pursuant to this Authorization.

I understand that Service Providers may be compensated by Sobi. The Service Providers will use, redisclose and give out my child's information to (i) assist in my child's enrollment in SYNAGIS CONNECT and to contact me and/or the person legally authorized to sign on my child's behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational material and other information materials related to the SYNAGIS CONNECT offerings; (iii) verify, investigate, assist with, and coordinate my child's coverage for SYNAGIS® (palivizumab) with my child's payer; (iv) coordinate prescription fulfillment; (v) assess my child's eligibility for patient assistance and/or benefits if necessary and applicable; and (vi) assist with analyses of the efficiencies and performance of services provided by Service Providers. In some instances, the Service Providers may de-identify my child's information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my child's information private; however, I understand that once my child's information has been disclosed to the Service Providers, how the Service Providers further disclose my child's information may no longer be protected under federal and state privacy laws.

This Authorization will last for three (3) years from the date of my signature or until I am no longer receiving SYNAGIS or enrolled in SYNAGIS CONNECT, whichever is later, unless a shorter period is mandated by state law. MARYLAND HEALTHCARE PROVIDERS, under Md. Code HG § 4-303(b)(4) this authorization expires ONE YEAR from the date of signature. I understand that I do not have to sign this authorization, but if I do not, my child will not be able to have their insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of SYNAGIS CONNECT. My choice as to whether to sign this form will not change the way my child's doctors, healthcare providers, or payers treat my child.

I have the right to revoke or cancel this Authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of SYNAGIS CONNECT at PO Box 1989, Columbus, OH 43216 or I can cancel this Authorization at any time by calling SYNAGIS CONNECT at 1-833-SYNAGIS (1-833-796-2447). If I chose to cancel my child's participation in SYNAGIS CONNECT it means that I no longer want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. Cancellation of this Authorization will be valid when received by the administrators of SYNAGIS CONNECT. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I know I have a right to see or request a copy of the information my child's healthcare providers or payers have given to the Service Providers. If I receive services offered under SYNAGIS CONNECT, I agree to allow Company and Service Providers to contact me via email or cell phone using the contact information provided in this enrollment form.