

1. I am participating in the RUCONEST SOLUTIONS Program ("Program") operated by Pharming Healthcare Inc. which provides me certain clinical and nursing support services related to my use of the biologic RUCONEST, manufactured by Pharming Healthcare Inc., for treatment of my HAE condition. The Program is administered by the Lash Group. This authorization will allow Pharming Healthcare Inc., the Lash Group, my pharmacy, healthcare providers, and health plan to use and disclose certain health information about me to facilitate my treatment with RUCONEST and to improve the Program for the benefit of future patients with HAE. I hereby authorize the use or disclosure of my protected health information (PHI) defined below for the purposes described in Section 5 below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive and use my PHI is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and there is a potential for my PHI to be subject to redisclosure by the recipients.
2. Persons/organizations who may disclose my PHI:
 - Pharming Healthcare Inc. and its authorized representatives ("Pharming")
 - Lash Group
 - My pharmacy(ies) providing the RUCONEST
 - My healthcare provider(s), including physicians and home care nurse educators
 - My health plan(s) providing medical care and prescription coverage
3. Persons/organizations who may receive and use my PHI:
 - Pharming Healthcare Inc. and its authorized representatives
 - Lash Group
 - My pharmacy(ies) that provide RUCONEST
 - My healthcare provider(s), including physicians and home care nurse educators
 - My health plan(s) providing medical care and prescription coverage
4. My PHI consists of the following information about me that may be used or disclosed:
 - Information I provided on the RUCONEST Enrollment Form
 - My healthcare records related to my treatment and HAE condition
 - My health insurance information regarding my coverage, copay, deductibles, and benefit options
 - My prescription information, such as status, fulfillment, and/or shipment of my medication
 - My hospital records for any hospitalization and information related to my transition of care
5. My PHI may be used and disclosed for the following purposes:
 - Administration of the Program
 - Internal data collection and reporting
 - Tracking items such as health/prescription plan coverage, patient cost, shipments of the RUCONEST, health plan coverage trends, use of the Program offerings
 - Nursing services for the purposes of improving the quality of the Program
 - Assessing ongoing and future needs of patients who are prescribed RUCONEST
 - Analyzing the quality, efficacy, and safety of RUCONEST
6. I understand that the specialty pharmacies that dispense my medication may be paid for sharing my PHI with the Program and Pharming so that the recipients may use it for the purposes specified in this authorization.
7. My authorization will remain in effect for two (2) years from the date of my signature unless I revoke it before then. I understand that I may be requested to provide my written authorization on an annual basis by the Program to support continued access to my PHI. I understand that after I have signed this authorization, I may revoke it at any time by sending a written notice to the RUCONEST SOLUTIONS Program at PO Box 221974, Charlotte, NC 28222-1974. The revocation goes into effect once it has been received by the RUCONEST SOLUTIONS Program, and my healthcare providers and health plan, but the revocation will not affect any of my PHI already disclosed in reliance on this authorization.
8. I understand that I can refuse to sign this authorization and it will not affect the start, continuation, or quality of my treatment from my healthcare provider, payment for my treatment or my eligibility for or enrollment in health coverage.

However, I understand that if I choose not to sign this authorization or revoke it after signing this form, the Program will not be able to provide me with the support described above, after the date of revocation.
9. I understand that I am entitled to a copy of this Authorization after signing below.

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Signature of patient or patient's representative (if signed by someone other than the patient)

Date

.....
Printed name of patient or patient's representative

Relationship to patient

Please see accompanying full Prescribing Information, including Patient Product Information [here](#), or visit www.ruconest.com.