RUCONEST SOLUTIONS™
Expertise. Delivered personally.

Patient Consent Form

Fax completed forms to: 1-855-423-5757

RUCONEST®
C1esterase inhibitor (recombinant)

Patient Name: _____ **DOB:** _____

Patient Email: _____ **Patient Phone (Cell):** _____

Emergency Contact Name: _____ **Relationship to Patient:** _____

Emergency Contact Phone: _____

Consent to Share Health Information: By signing this Consent, I authorize my healthcare provider, including physicians and home care nurse educators, my health plan(s) providing medical care and prescription coverage, and my pharmacy(ies) providing the RUCONEST to disclose to RUCONEST Solutions ("Program") operated by Pharming Healthcare and companies working with Pharming Healthcare, health information relating to my medical condition, treatment, and insurance coverage. I also authorize my healthcare provider, including physicians and home care nurse educators, my health plan(s) providing medical care and prescription coverage, and my pharmacy(ies) providing the RUCONEST to receive health information related to my medical condition, treatment, and insurance coverage from the Program. I authorize Pharming Healthcare to provide me with (i) support services (and related information and materials) related to any of Pharming Healthcare's products, including but not limited to, insurance coverage, prescription fulfillment, online support, financial assistance services, adherence, and other therapy support services; and (ii) information about Pharming Healthcare's products, services, and programs. I understand that Pharming may use my health information to conduct data analytics, market research, and other internal business activities. Once my health information has been disclosed to Pharming Healthcare, I understand that federal privacy laws no longer protect the information. However, Pharming Healthcare agrees to protect my health information by using and disclosing it only for purposes authorized in this Consent or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Pharming Healthcare in exchange for the health information and/or for any therapy support services provided to me. I understand that I may refuse to sign this Consent. I further understand that my treatment (including with a Pharming Healthcare product), insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Consent; but if I do not sign it or later cancel it, I will not be able to receive Pharming Healthcare's patient program support. I may cancel this consent at any time by calling (855) 613-4423. Canceling this Consent will end my consent to further disclosure of my health information to Pharming Healthcare by my Healthcare Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Consent. Canceling this Consent will not affect my ability to receive treatment, or my eligibility for health insurance. This Consent expires five (5) years from the date signed unless a shorter period is required by state law. I understand that I am entitled to a copy of this Authorization after signing below.

Patient Support Services: I authorize the Program and its affiliated team members to contact me to provide me support related to any of Pharming Healthcare's products, including but not limited to insurance coverage, prescription fulfillment, product assistance, financial assistance services, adherence, and other therapy support services, relevant disease-related information, as well as any information or materials related to such services. I understand that any personnel providing support as part of the Program are not employed by my healthcare professional. RUCONEST Solutions or Pharming Healthcare may contact me by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice),* and other mutually agreed upon means. I also authorize Pharming Healthcare to use my health information in connection with the services and programs, including, without limitation, sharing such information with my Healthcare Entities.

Opt-in for Other Resources: By signing below, I authorize Pharming Healthcare, and companies working with Pharming Healthcare, to contact me by mail, email, fax, text messaging,* and/or telephone regarding other potential topics of interest to me, customer surveys, or occasionally for market research purposes. I understand that I am not required to provide this consent as a condition of receiving any Pharming Healthcare medicine or Patient Support Services. Note that Pharming Healthcare will not sell or trade my personal data to any unrelated third party.

☐ I would like to **opt out** of receiving other resources

Emergency Contact: I authorize RUCONEST Solutions, my doctor, my pharmacist, or any representative attempting to provide me with access to RUCONEST to contact the emergency contact listed above on my behalf in the event of an emergency.

By signing below, I confirm that I have read and understand the Consent to Share Health Information and Patient Support Services above and agree to the terms.

Printed Patient/Legal Representative Name: _____

Patient Sign

Patient/Legal Representative Signature: _____ Date: _____

If Legal Representative, Relationship to Patient: _____

*Data rates may apply.

For more information, please read the full Prescribing Information.