

Patient Name: _____ DOB: _____

Patient Email: _____ Patient Phone (Cell): _____

Authorization to Share Health Information: By signing this Authorization, I authorize my healthcare providers (e.g., physicians, pharmacies, other healthcare professionals, facilities and staff) and insurers (e.g., health insurance plans) to share my protected health information with Pharming Healthcare, Inc., and its agents and representatives (“Pharming”) for the purposes of enrolling me in and providing me services through Pharming’s RUCONEST Solutions (“Program”). I authorize Pharming to receive and use my health information (including information about my medical condition, treatment, and insurance coverage), my contact information and any other information I or my healthcare providers or insurers provide to Pharming (“My Information”). I also authorize my healthcare providers and insurers to receive My Information from the Program. I consent to Pharming enrolling me in the Program and providing me with support related to any of Pharming’s products, such as insurance coverage, prescription fulfillment, online support, financial assistance services, adherence, and other therapy support services. I understand that personnel providing support as part of the Program are not employed by my healthcare provider(s). I understand that Pharming may use My Information for: determining my eligibility (or ineligibility) to participate in the Program and providing Program services (such as prescription fulfillment, free product assistance programs, financial assistance services, adherence, insurance coverage assessment, and other therapy support services as further described at www.ruconest.com/patient-support); evaluating, improving or developing the Program; conducting data analytics and market research; communicating with me; and for Pharming’s internal business purposes. Once My Information has been disclosed to Pharming, I understand that federal privacy laws no longer protect the information. Pharming agrees to protect My Information as required by law. I understand that Pharming may remunerate service providers, including pharmacies, in exchange for My Information and/or for therapy support services provided to me. I further understand that my treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my signing this Authorization and I may refuse to sign it; but if I do not sign it or later cancel it, I will not be able to participate in the Program. This Authorization expires five (5) years from the date signed unless a shorter period is required by law, or until I am no longer participating in the Program. My Information that is collected before cancellation may continue to be used for the purposes set forth in this Authorization. I may cancel this Authorization at any time by calling (855) 613-4423 or sending an email to info@pharming.com. Canceling this Authorization will not affect how Pharming uses and shares My Information prior to my cancellation. I understand that I am entitled to a copy of this Authorization after signing below. By providing my contact information to Pharming, I authorize the Program to contact me via any of the contact methods provided by me on this Authorization form to provide me support related to any Program services listed above and/or to provide me with information about insurance coverage, prescription fulfillment, product assistance, financial assistance services, adherence, other therapy support services, relevant disease-related information, potential topics of interest to me, customer surveys, or occasionally for market research purposes. I understand that I may opt out of these communications at any time by contacting Pharming at 855-613-4423 or replying “STOP” to any text message I receive. For text messages, reply “HELP” for help or “STOP” to opt-out of receiving marketing texts. Message frequency varies.*

Consent for Collection and Use of Health Information: By signing below, I consent to the collection and use of my health information, contact information and other identifying information by Pharming, which I, my healthcare providers or others share with Pharming for the purposes described in this form and as further described in the Pharming Privacy Policy at www.pharming.com/privacy-statement

Opt-In for Marketing Communications (Optional): By checking this box, I consent to receive automated and recurring phone calls and text messages from Pharming for the purpose of sending me marketing messages about Pharming products or services. I understand that I am not required to provide this consent as a condition of participating in the Program. For text messages, reply “HELP” for help or “STOP” to opt-out of receiving marketing texts. Message frequency varies.*

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 below on my behalf in the event of an emergency.

Emergency Contact Name: _____

Email: _____ Phone: _____

By signing below, I confirm that I have read this Authorization form and agree to its terms.

Printed Patient/Legal Representative Name: _____

Patient/Legal Representative Signature: _____ Date: _____

Patient Sign

*Data rates may apply.

For more information, please read the full Prescribing Information.