NS Support
NS PHARMA ACCESS SOLUTIONS

833-NSSUPRT (833-677-8778)

NS Support Patient Consent Form

SEND THE COMPLETED FORM TO NS SUPPORT USING ONE OF THE FOLLOWING OPTIONS:

UPLOAD: https://nssupport.iassist.com/upload
EMAIL: nssupport@nspharma.com
FAX: 888-212-0482
MAIL: PO Box 7613, Overland Park, KS 66207

This form is for patients to complete. By providing full information and signatures, processing delays can be avoided.

PATIENT (OR LEGALLY AUTHORIZED REPRESENTATIVE) CONSENT

PATIENT NAME _____ DOB MM/DD/YYYY

Authorization to share and use Protected Health Information

My (or my legally authorized representative's) signature below authorizes each of my physicians and pharmacists (including any specialty pharmacies and other healthcare providers) and each of my health insurers to use and disclose my Protected Health Information ("PHI"), including but not limited to medical records, information related to my medical condition and treatment, financial information, lab values, insurance coverage information, my name, address, and telephone number, to NS Pharma, Inc., ("NS Pharma") and its NS Pharma patient support team, agents, contractors, and assignees ("Company") to: (i) enroll me in NS Pharma patient support services ("NS Support"), (ii) contact me (or my legally authorized representative) about NS Support and provide case management services to me (or my legally authorized representative), (iii) send me (or my legally authorized representative) educational information/communications, (iv) assist with adherence to my medication regimen, (v) work with third parties to provide community resources and referrals, and (vi) send me promotional and educational communications as further explained in the Communications consent section below. I (or my legally authorized representative) further authorize Company to use my information to provide case management by mail, email, phone calls, detailed voice messages, interactive voice recordings that may include use of auto-dialers or artificial or prerecorded voice messages, and SMS text messages (data rates may apply), to assist with adherence to my medication regimen and to work with third parties to provide community resources and referrals. I understand that I (or my legally authorized representative) can opt out of communications, including SMS text messages, at any time. Third-party vendors, such as specialty pharmacies, may receive financial remuneration in exchange for data, product support services, reimbursement services, etc. This consent expires 5 years from the date of execution unless a shorter period is required by state law. I (or my legally authorized representative) understand that I (or my legally authorized representative) may refuse to sign this consent and that my treatment, payment, enrollment, or eligibility for benefits, including my access to therapy, is not conditioned on signing this consent. I (or my legally authorized representative) understand that disclosure of my PHI to NS Pharma means that my information may no longer be protected under federal privacy laws, but that NS Pharma will protect my information in accordance with its Privacy Notice (nspharma.com/privacy-notice).

Revoking this authorization

A copy of this consent will be as valid as the original. I (or my legally authorized representative) understand that revoking this consent will not affect the ability to use and disclose PHI received prior to receipt of notification that I (or my legally authorized representative) wish to discontinue my participation in the program. I (or my legally authorized representative) understand that I (or my legally authorized representative) may revoke this consent at any time verbally by calling 833-NSSUPRT (833-677-8778) or in writing to NS Support at PO Box 7613, Overland Park, KS 66207-9941 or nssupport@nspharma.com. My (or my legally authorized representative's) consent will also end if NS Support is discontinued. Once consent has been revoked or expired, I (or my legally authorized representative) understand that my future PHI will not be disclosed for any other purposes, unless permitted by law, than for the purposes stated above. Information disclosed pursuant to this consent or provided to a third party may no longer be protected by federal privacy laws. I (or my legally authorized representative) understand that I (or my legally authorized representative) have a right to receive a copy of this consent and/or copies of any Protected Health Information my healthcare providers or insurers have given to Company.

Communications consent

By providing my signature below, I (or my legally authorized representative) authorize NS Pharma to send to me (or my legally authorized representative) promotional and/or educational patient communications related to my condition, treatment, or related products or services that might be of interest. I (or my legally authorized representative) consent to NS Pharma contacting me (or my legally authorized representative) occasionally to obtain feedback for market research purposes about my treatment, condition, or experience with the product, NS Pharma, and/or NS Support, and to contact me (or my legally authorized representative) about other products and services offered by NS Pharma, including promotional and/or educational patient communications related to my treatment and condition. Examples of these communications may include, but are not limited to, product information, patient programs, newsletters, announcements, healthcare reminders, and tips. **I (or my legally authorized representative) understand that I (or my legally authorized representative) may opt out of receiving these communications at any time by following the instructions on the communications.**

Permission to be enrolled in NS Support

NS Support may offer product-specific support programs in accordance with guidelines established by NS Pharma ("NS Support Programs"). I (or my legally authorized representative) understand that each product-specific program will have its own terms and conditions and eligibility requirements, and I and my physician may be required to submit additional information to qualify for any product-specific program.

I (or my legally authorized representative) understand that signing this form does not guarantee eligibility for any specific program, as each offering has different requirements. Also, to qualify for certain product-specific programs, I must meet certain income and other eligibility requirements, and that NS Pharma will use this information to help determine my eligibility but may ask for proof of income or other documentation at any time for the purpose of eligibility or audit/verification.

TOTAL HOUSEHOLD SIZE* _____ (Includes yourself, your spouse, and any dependents currently living with you)

TOTAL ANNUAL HOUSEHOLD INCOME $* _____ (Includes salary and wages, Social Security payments, income from retirement plans and pensions, alimony payments you receive, and interest and dividend income. These earnings added together for the entire household will give you your total household income)

*Optional.

PATIENT (OR LEGALLY AUTHORIZED REPRESENTATIVE) CONSENT AND CONSENT FOR THE COLLECTION OF HEALTH INFORMATION

This form can also be completed online at: nssupport.iassist.com/consent

If completing this form as the Legally Authorized Representative on behalf of the patient, by providing my signature and checking the box below regarding my relationship to the patient, I certify that I have proper authority to act on behalf of the patient to the best of my knowledge.

IF SIGNED BY LEGALLY AUTHORIZED REPRESENTATIVE, STATE RELATIONSHIP TO PATIENT AND INDICATE YOUR AUTHORITY TO ACT ON BEHALF OF PATIENT:

❑ RELATIVE ❑ GUARDIAN ❑ POWER OF ATTORNEY (including for healthcare decisions)

SIGNATURE _____ DATE MM/DD/YYYY

EMAIL _____ PHONE (XXX) XXX-XXXX ❑ MOBILE ❑ LAND

Consent is valid for 5 years from signature date. Patients will be given the option to provide their own consent once they turn 18 years of age.

Questions? Call NS Support at 833-NSSUPRT (833-677-8778), Monday–Friday, 8AM–8PM ET.

NS Pharma