

PATIENT AUTHORIZATION FORM (PA)

Provider Instructions: Patients must complete this form before they can participate in the Program.

I, _____, allow my doctor(s), any other healthcare providers, and my health plan or insurers to give medical information relating to my use or need for EUFLEXXA® to CareMed, the administrator of the Euflexxa Solution Center®. CareMed, the administrator of the Euflexxa Solution Center® (the "Program") for Ferring, maker of EUFLEXXA.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my healthcare providers or health plans about my health or healthcare. CareMed will use and give out this information to help find ways to pay for EUFLEXXA and related services and to run Euflexxa Solution Center®. CareMed may also give my information to other related parties of this program, if they first take out any information that identifies me.

CareMed will use and give out this information to see if I qualify for the Program and to run the Program. In addition, CareMed may use and give out my information to refer me to other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my drugs. People, who work for and with CareMed, may also see my information, but they may use it only in connection with the Program, to help me get assistance with the costs of my drugs, or as otherwise required or allowed under the law. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. If I change my mind before that time, I can tell my healthcare providers and my insurers in writing that I do not want them to share any more information with CareMed but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my healthcare providers or insurers have given to CareMed.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my healthcare providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient sign here: _____ Date: _____

Patient name: _____

If the patient cannot sign, patient's personal representative must sign below:

Patient name: _____

By: _____

(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient:

A copy of this form must be provided to the patient.

Fax completed form to 1-866-EUFLEX2 (1-866-383-5392)

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