

Patient Authorization Form for RADICAVA ORS[®]

INSTRUCTIONS

- If the patient or legal representative hasn't signed a **Benefit Investigation and Enrollment Form for RADICAVA ORS[®] (edaravone)**, they must review, complete, and sign the pages in this form to authorize **JourneyMate Support Program[™]** services.
- The patient or caregiver must receive a copy of all pages of this form for their records.

PATIENT AUTHORIZATION

I authorize each of my physicians and pharmacists, including any specialty pharmacy that receives my prescription for RADICAVA ORS[®] (edaravone) and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to use and disclose my personal information, including, but not limited to, contact information, demographic information, financial information, medical records and history, information related to my medical condition and treatment, information related to my health insurance and benefits (together, "Personal Information") to Tanabe Pharma America, Inc., its affiliated companies, agents and representatives (together, "Tanabe Pharma America" or "TPA"), including providers of alternate sources of funding for prescription drug costs, and vendors providing relevant patient education programs and other service providers supporting access and assistance programs for Healthcare Providers and patients for the purposes described below (**JourneyMate Support Program[™]**).

I specifically authorize TPA to receive, use, and disclose my Protected Health Information for the following purposes:

- to enroll me in, and contact me and/or the person legally authorized to sign on my behalf about, the **JourneyMate Support Program[™]**, including potential enrollment in the Out-of-Pocket Assistance Program for RADICAVA ORS[®] if I am an eligible, commercially insured patient with insurance coverage for RADICAVA ORS[®], or the Patient Assistance Program, if I have no insurance and meet eligibility requirements;
- to provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to RADICAVA ORS[®] and to contact me about enrolling in a relevant patient education program;
- to provide access support education, including contacting my Healthcare Providers regarding my coverage for RADICAVA ORS[®];
- to assist with analyses related to the quality, efficacy, and safety of RADICAVA ORS[®] and patient access to and treatment compliance with RADICAVA ORS[®];
- to enhance and improve the product access services; and

TPA may use my Personal Information to contact me for any of these purposes by mail, email, and telephone. To opt out of receiving future communications about product access services, I may call the **JourneyMate Support Program[™]** at 1-844-772-4548 or follow the instructions in any communication I receive. I understand that if I opt out from receiving communications, I will no longer be able to participate in or receive assistance from the Out-of-Pocket Assistance Program for RADICAVA ORS[®].

GENERAL INFORMATION

I understand that pharmacies that ship my medication may be paid to share my Personal Information with the **JourneyMate Support Program[™]** for the purposes listed in this Patient Authorization. I also understand that my Personal Information will not be used or disclosed by TPA for any other purpose than described in the Benefit Investigation and Enrollment Form without my authorization unless permitted or required by law or unless information that identifies me is removed so that the information is "de-identified."

I understand that information used or disclosed under this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law. For additional information on how TPA collects, uses, and discloses Personal Information, I can visit us.tanabe-pharma.com/privacy-policy.

I understand that I am not required to sign this Patient Authorization for RADICAVA ORS[®]. I further understand that my decision on whether to sign will have no effect on any treatment, payment, or eligibility with my Healthcare Provider or Insurer. If I do not sign the Authorization on page 2 of this form, or cancel (revoke) my Authorization later, I understand that this means I will not be able to participate in or receive assistance from the **JourneyMate Support Program[™]**. This Authorization will remain in effect for 5 years from the date of my signature, or until I am no longer participating in **JourneyMate Support Program[™]** services, whichever is sooner, unless a shorter period is required under the laws in the state I reside. A copy of this Authorization will be as valid as the original. I may cancel this Authorization at any time in writing by mailing a letter to **JourneyMate Support Program[™]**, 680 Century Point, Lake Mary, FL 32746. Cancelling this Authorization will not affect the ability of TPA to use and disclose Personal Information that it has received prior to receipt of the cancellation of my Authorization. My Authorization will also end if the **JourneyMate Support Program[™]** is discontinued. Furthermore, I understand that I have the right to receive a copy of this Patient Authorization and to see or copy the Personal Information my Healthcare Providers or Insurers have given to TPA.

Patient Authorization Form for RADICAVA ORS[®] (cont'd)

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient Authorization included on page 1 and agree to the release and use of my Personal Information for the purposes described above.

AUTHORIZATION TO RECEIVE MARKETING COMMUNICATIONS

- ☐ By checking the box, I authorize Tanabe Pharma America, Inc. ("TPA") and its collaborators, affiliates, and agents (third parties working with or on behalf of, TPA) (together the "TPA Parties") to receive, use, and disclose my Protected Health Information to (a) send me communications with optional information and/or materials related to disease state, products, promotions, services, research studies, and more, and (b) ask my opinion about such information and topics, including performing marketing research and disease-related surveys.

If you have provided a Mobile Phone number:

AUTHORIZATION TO RECEIVE EDUCATIONAL CALLS OR TEXT MESSAGES

- ☐ By checking this box and signing below, I am agreeing to receive recurring autodialed and/or pre-recorded marketing calls and recurring automated text messages to the number I entered on Page 3 of the Benefit Investigation and Enrollment Form from and on behalf of the **JourneyMate Support Program[™]** about ALS, treatment options, status, reminders and more. Consent is not required nor is it a condition for purchase. Message and data rates may apply. Text STOP to 85427 to stop (confirmation text may be sent). Text HELP to 85427 for help. I agree to the Terms of Use (us.tanabe-pharma.com/terms-of-use) and Privacy Policy (us.tanabe-pharma.com/privacy-policy).

AUTHORIZATION TO CONTACT YOU ABOUT SHARING YOUR STORY

- ☐ I may want to share my experience about my disease and RADICAVA ORS[®]. Please contact me after I start treatment.

I may consider creating: ☐ Video Content ☐ Written Content ☐ Both Video and Written Content

 **Patient Signature** _____ Date _____

If patient cannot sign above, patient's Legal Representative must sign below.

Name (Please Print) _____

Legal Representative Name (Please Print) _____

Nature of Relationship to Patient _____

By signing on this line, I certify under penalty of perjury that I am the legally authorized representative with authority to sign on behalf of the patient named herein.

Legal Representative Signature _____ Date _____

Witness Name (Optional) (Please Print) _____

Witness Signature _____ ☐ Notary

Patient Authorization Form for RADICAVA ORS[®] (cont'd)

PATIENT INFORMATION (REQUIRED)

First Name _____ MI _____ Last Name _____ Suffix _____

Address _____

City _____ State _____ ZIP _____

Email _____

 DOB (MM/DD/YYYY) _____ Gender ☐ M ☐ F ☐ Prefer not to say

 Phone Number _____ This Number Is: ☐ Mobile ☐ Home ☐ Okay to Leave Voicemail

 Language Preference (if Not English) _____ Are You Nonverbal? ☐ Yes ☐ No
(If Yes, Select "Additional Contact" as Preferred Contact Person Below.)

Additional Contact Name _____

Relationship to Patient _____

 Phone Number _____ This Number Is: ☐ Mobile ☐ Home ☐ Okay to Leave Voicemail

 Preferred Contact ☐ Me ☐ Additional Contact Preferred Method ☐ Phone ☐ Text ☐ Email

Please see the accompanying full Prescribing Information and Patient Information, also available at www.RadicavaORS.com.



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The corporate symbol of Tanabe Pharma America is a registered trademark of Tanabe Pharma Corporation.

JourneyMate Support Program is a trademark of Tanabe Pharma America, Inc.

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