PATIENT AUTHORIZATION FORM

My signature authorizes my doctor(s), my healthcare providers, my discharge planners, my health plan or payor, and my pharmacy to disclose certain information about me to Astellas ("Company") and its third-party suppliers, vendors, and other service providers supporting Astellas Pharma Support Solutions[SM] (collectively, the "Service Providers"). The information about me (for example, my name, Social Security number, address, insurance policy number and income) and my medical condition (for example, my diagnosis or medications) is referred to together as "Personally Identifiable Information". This information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my information based on this authorization.

I understand that Service Providers including Astellas Pharma Support Solutions ("APSS") may be compensated by Astellas. The Service Providers will use and give out my information to (i) assist in my enrollment in APSS and to contact me and/or the person legally authorized to sign on my behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational and other materials, information, and services related to APSS; (iii) verify, investigate, assist with, and coordinate my coverage for Company medicines with my payor; (iv) coordinate prescription fulfillment; (v) assess my eligibility for patient assistance and/or benefits, if necessary; (vi) make referrals to other independent programs or alternate sources that may be available to provide me assistance as allowed under the law if necessary; and (vii) assist with analyses of the efficiencies and performance of Services provided by Service Providers. In some instances the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This authorization will expire three (3) years from the date of my signature on this authorization. I do not have to sign this authorization, but if I do not, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other services provided by or on behalf of APSS. My choice as to whether to sign this authorization form will not change the way my doctors, healthcare providers, or payors treat me. If I no longer wish to participate in APSS, I shall inform my healthcare providers and/or the administrators of APSS in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of APSS.

Cancellation of this authorization will be valid when received by the administrators of APSS. I understand that a cancellation is not effective to the extent that any person or entity has already acted based on my authorization. I know I have a right to see or copy the information my healthcare providers or payors have given to the Service Providers.

If an application is submitted to determine my eligibility for assistance from the Astellas Patient Assistance Program ("PAP"), I agree to allow Company and Service Providers to use my demographic information, including but not limited to Social Security number, date of birth, name, and/or address as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the PAP. Company and Service Providers reserve the right to ask for additional documents and information at any time. I agree to notify my healthcare providers if I become aware in the future of changes that would affect my eligibility, including but not limited to changes in health insurance status or coverage, financial status, and United States residing status.

This Patient Authorization Form is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

*A component of Astellas Pharma Support Solutions

Description of Services

Company, through APSS, has developed an integrated approach of customized access and reimbursement services to help patients minimize potential barriers to accessing Company medicines ("Services"). These Services are designed to help healthcare providers and patients evaluate a patient's coverage and reimbursement options for Company medicines. The patient signature on this Authorization Form authorizes the Service Providers to perform any or all of the following Services, if necessary, to assist with patient access to a Company Medicine.

- Perform Benefits Verification/Prior Authorization (PA) information (if PA is required by payor)
- Referral to specialty pharmacy, if applicable
- Assist in Benefits Appeal
- Determine eligibility for Free Drug Program through the Astellas Patient Assistance Program
- Provide educational services
- Make referral to other independent programs or alternate sources that may be available to provide patient with assistance

Perform Benefits Verification/Prior Authorization (PA) (if PA is required by payor) – A Benefits Verification allows a Service Provider to call a patient's insurance plan to investigate specific coverage for a Company medicine. During the call, a Service Provider may inquire about patient eligibility for benefits, coverage restrictions, deductible, copayment or coinsurance, and benefit maximum amounts, and any other payor requirements. A Service Provider may provide the healthcare provider and/or payor with a summary of the Benefits Verification research.

If PA is required, a Service Provider will use reasonable efforts to provide the healthcare provider information on what to submit to the payor, the submission process, and an estimation of how long it will take the payor to make a determination.

Referral to Specialty Pharmacy – This service allows Service Providers to call a patient's insurance plan to confirm in-network pharmacy options and forward the prescription directly to the appropriate specialty pharmacy, if necessary. If applicable, Service Providers will provide the healthcare provider a summary of the prescription referral to such Pharmacy or third party.

Assist in Benefits Appeal – If a payor denies coverage for a Company medicine, Service Providers may assist the healthcare provider with appealing the payor's decision. This means that a Service Provider may use reasonable efforts to provide the healthcare provider and/or the pharmacy provider information on what to submit to the payor, the submission process, and an estimation of how long it will take the payor to make a determination.

Determine eligibility for Free Drug Program through the Astellas Patient Assistance Program – The Astellas Patient Assistance Program was established to provide certain Company medications at no cost to patients who meet the eligibility requirements. A Service Provider may obtain information from patients, such as insurance status and income in order to determine eligibility. If a patient is approved, a Service Provider will notify both the healthcare provider and patient and schedule a shipment of Company medicine for delivery to the patient.

Provide Educational Services – The Service Providers and the Company may provide educational and other information on Company medicines via mail, e-mail, phone, or other methods of communication. This may include activities like sending educational and/or other materials, or offering programs to promote patient education and medication adherence for Company medicines.

Make Referral – The Service Providers may refer patient to other independent programs or alternate sources that may be available to provide patient with assistance as allowed under the law.

Patient Signature

By signing below, I provide my agreement to this written consent and authorization which certifies that I have read and understand the above Patient Authorization Form.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

If signed by a representative, please describe the representative's authority to act on behalf of the patient: _____

I am acting for another person and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or otherwise have a valid power of attorney to act on behalf of the patient.

Representative Signature: _____ Date: _____