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 Personally Identifiable 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 Personally Identifiable Information based on this authorization. I understand my Personally Identifiable Information will be used and disclosed by Company in accordance with its privacy policy, available at www.astellas.com/us/privacy-policy.

I understand that Service Providers including Astellas Pharma Support Solutions ("APSS") may be compensated by Astellas. The Company and Service Providers will use and disclose my Personally Identifiable 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. Service Providers and Company may use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Company and Service Providers will make reasonable efforts to keep my Personally Identifiable Information private; however, I understand that once my information has been disclosed to the Service Providers, it may no longer be protected under federal and state privacy laws and could be disclosed to others.

This authorization will expire three (3) years from the date of my signature on this authorization, unless a shorter period is required by law. 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. 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, if I cancel my authorization, the Company and the Service Providers will no longer be able to provide me with the services described above. I also 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.

I authorize Company and Service Providers to access my consumer report from a consumer reporting agency (credit bureau), other credit information, and public record information (collectively "Financial Records") to estimate my income in conjunction with determining my eligibility for assistance from the Astellas Patient Assistance Program ("PAP"). I authorize 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 such financial records 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. By signing this form, I certify that I cannot afford my medication, and I affirm that the information provided on this form is true and complete to the best of my knowledge. I understand that completing this form does not guarantee that I will qualify for the PAP. I will promptly contact the PAP if my financial status or insurance coverage changes. I agree that, at any time during my application to, or participation in the PAP, the Company may request additional documentation to verify my personal information. If there is missing information or I do not respond to requests for additional documents, my participation may be delayed or I may no longer be able to participate in the PAP. If I qualify for, and receive free medication from the PAP, I agree to comply with the PAP program rules and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that assistance may be temporary and that I may be required to apply every year. I understand that any medicines supplied by the PAP shall not be sold, traded, bartered, or transferred. I further understand that Company reserves the right to change or cancel the PAP, or terminate my enrollment, at any time, without notice, and that the support provided through the PAP is not contingent on any future purchase.

I understand that I am entitled to receive a copy of this Authorization Statement after I have provided my signature.

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.

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) (if PA is required by payor)
- Referral to specialty pharmacy, if applicable
- Assist in Benefits Appeal
- Determine eligibility for Free Drug Program through the PAP
- Provide educational services

- Provide information about independent programs, or alternate coverage sources, that may be available to provide patient with assistance

Perform Benefits Verification/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 PAP – The PAP 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, email, 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.

Provide information about independent programs or alternative coverage sources that may be able to help patients afford their medications – 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: _____