FOR US CONSUMERS

CYCLE PHARMA

Nityr® nitisinone Tablets

PHONE: 1-800-847-8714
FAX THIS FORM: 1-800-842-5163
www.nityr.us

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI)

Patient's Full Name (First, Middle initial and Last name):

_____

Parent/Guardian name (if applicable): _____

Patient's Address: _____

City: _____ State:_____

Home/Cell/Work Phone:_____

Alternate Caregiver/Contact:_____

☐ OK to leave message with Alternate Caregiver/Contact

Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

Relation: _____ Preferred Language: _____

Suite/Floor/Apt #: _____

Patient's Zip code: _____ E-mail: _____

Home Phone: _____

Alternate Caregiver E-mail:_____

Alternate Phone Number:_____

I understand that I must complete this enrollment form before I can receive assistance through the Cycle Pharmaceuticals, Ltd. *NITYR® Patient Support Program*. As part of this process, CYCLE and its agents and contractors (collectively, "CYCLE") will need to obtain, review, use and disclose PHI as described below.

To ensure I have access to the *NITYR® Patient Support Program* benefits for which I may qualify AND to ensure my Personal Health Information (PHI) is appropriately protected in compliance with applicable federal laws and regulations:

- **I hereby authorize the *NITYR® Patient Support Program* to contact me by mail, e-mail, text, phone, or any communication method I request** for the purposes as described herein.
- **I further authorize my healthcare providers (HCPs) and health plans to disclose my PHI as described below to an authorized CYCLE Health Care Professional (HCP) in connection with *NITYR® Patient Support Program***, and I authorize CYCLE to use and disclose the information for the purposes stated in this authorization.

1. Information to Be Disclosed: Personal health information (PHI), including information about me (for example, name, mailing address, financial information, and insurance), my past, current and future medical condition and information provided on this form.

2. Persons Authorized to Disclose My Information: My HCPs, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me healthcare benefits.

3. Persons to Whom My Information May Be Disclosed: A qualified HCP e.g. a nurse, representing CYCLE, including third-party administrator responsible for the administration of the *NITYR® Patient Support Program*. I understand my PHI will only be shared in accordance with my consent as described within this form.

4. Purposes for Which the Disclosures Are to Be Made: Disclosures of PHI may be made to CYCLE so that CYCLE may use and disclose the PHI for purposes of completing the enrollment process and verifying my enrollment form and establishing my eligibility for *NITYR® Patient Support Services* and benefits that may include:

a) **Insurance and Reimbursement Assistance**: Authorization allows for professional assistance at no charge on Patient's behalf for Claims Settlement; Claims Submission - to health insurers (for payment); communication of relevant claim information to/from HCPs and Insurance carriers.
b) **Reimbursement Services & Support**: Financial Assistance for eligible patients. Including CYCLE's sponsored Co-Pay Assistance. Allowing *CYCLE Pharmaceuticals Ltd*. to pay associated Co-Payments due Insurance providers on behalf of the Patient (up to $15,000 per year per patient). For eligible commercially insured patients.
c) **Patient Benefits Investigation & Payer Prior-Authorization Support**: *NITYR® Patient Support Program* will contact, investigate and arrange for Patient's coverage with their respective Health Insurer and/or PBM (Pharmacy Benefit Manager), as well as support and appropriately assist with Prior-Authorizations.
d) **Continuous Medication Supply** (NITYR®): As necessary, which may include immediate medication (NITYR®) delivery for Patient while Insurance coverage is coordinated. CYCLE will send NITYR® at no cost, immediately ("Quick Start") and/or continue to supply medication ("Bridge") if coverage lapses.
e) **Diet Food Program**: The *NITYR® Patient Support Program* will supply eligible *NITYR®* patients a $200 monthly Coupon for *Ajinomoto Cambrooke Inc.* product for up to 24 months. Subject to terms and conditions and eligibility criteria. This program is for eligible commercially insured patients only. Not available for government-insured patients and subject to other federal and state law. Full terms and conditions are available at: https://www.nityr.us/offertcs
f) **21-Day Free Trial Program:** The *NITYR® Patient Support Program* will supply eligible *NITYR®* patients with 21-Day free supply of *NITYR®* tablets. Patient can try *NITYR®* for 21 days for free as long as their doctor prescribes it. Subject to terms and conditions, eligibility criteria and to other federal and state law. Full terms and condition are available at: https://www.nityr.us/offertcs
g) **Healthcare Professional Availability (24/7)**: The *NITYR® Patient Support Program* includes 24-hour availability of a Dietitian, Nurse, Pharmacist, Patient Service Manager, and/or Field Nurse Patient Liaison. Not intended to replace local HCPs, only an added resource available to patients. The *Field Nurse Patient Liaison* is available to meet with Patients and/or Caregivers locally to support and assist patients, and access and administration to medication.
h) **Patient Education and Information**: CYCLE and the *NITYR® Patient Support Program* will provide Patients with full education on *NITYR®* administration, relevant disease area information and product information updates; in addition to pertinent updates and information on events for patients. This includes advocacy communication from national and international patient advocacy groups.
i) **Access to Manufacture / CYCLE**: This will allow CYCLE to alert Patients receiving *NITYR®* about relevant product and market updates, and available resources, including adherence tools, diet tips, recipes, and other programs to benefit patients with Hereditary Tyrosinemia Type I.

5. Limits of Protections after Disclosure. I understand that once my PHI has been disclosed hereunder, federal privacy law may no longer restrict its use or disclosure.

6. Option to Refuse. I understand **I am not required to sign this Authorization as a condition to receive treatment with CYCLE's products,** or payment for health care; enrolling in a health plan; or establishing eligibility for benefits. However, **by refusing to authorize disclosure of my PHI to a qualified and authorized CYCLE HCP, I also understand that I am knowingly foregoing possible access to the *NITYR® Patient Support Program* benefits**.

7. Copy of Authorization and Ability to Cancel Authorization. I understand I **will be given a copy of this Authorization** after I sign it; and my Authorization shall remain in effect until it expires (i.e. 5 years from the date sign below unless a shorter period is required by the law of my state residence), or **unless I revoke Authorization at any time** by contacting *NITYR® Patient Support* on (toll-free) 1-800-847-8714 (9 am to 5 pm EST), by fax 1-800-842-5163 or or in writing to Cycle Pharmaceuticals Ltd., 200 Portland Street, 5th floor, Boston, MA 02114.

8. I understand that my pharmacy, health insurers and third-party vendors may receive payment from Cycle as the manufacturer in exchange for securely sharing my PHI to an authorized Cycle's HCP for the sole purpose of providing me access to important patient support services as described above.

WRITTEN AUTHORIZATION (To be completed by NITYR® Patient):

I have **read and understood the Patient Authorization Information** and by signing this form **consent to the release of my PHI to an authorized CYCLE HCP representative for the purposes related to providing access to the *NITYR® Patient Support Program* as stated in this form:**

***Signature of Patient or Patient Representative**_____ ☐ **Patient** ☐ **Patient Representative - Date:** _____

*** If by Patient Representative, please explain authority/relation to act on behalf of Patient:** _____ **Date:** _____