AVSOLA™ (infliximab-axxq) For Injection 100mg/vial | Co-Pay Program

PATIENT AUTHORIZATION FORM

PLEASE INSERT THE 8-DIGIT AVSOLA™ CO-PAY PROGRAM NUMBER LOCATED ON THE BOTTOM LEFT-HAND SIDE OF THE AVSOLA™ CO-PAY CARD.

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Program Number

AMGEN'S PATIENT AUTHORIZATION

USES AND DISCLOSURE OF PERSONAL INFORMATION

I authorize Amgen and its contractors and business partners ("Amgen") to use and/or disclose my personal information, *including my personal health information*, only for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in the **AVSOLA™ Co-Pay Program** or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse educator services, adherence program, and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
- **To provide me with informational and promotional materials relating to Amgen products and services and/or my condition or treatment;** and/or
- To improve, develop, and evaluate products, services, materials, and programs related to my condition or treatment.

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In order for Amgen to provide me with the services and/or programs described above, Amgen needs to collect and use my personal information, including my *personal health information*. I understand that my *personal health information* may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory, and/or their contractor ("Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care Providers to disclose my *personal health information* to Amgen, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing my *personal health information* and/or for using my information to contact me with communications about Amgen products that have been prescribed to me (for example, medication reminder programs) and other patient support services.

EXPIRATION, RIGHT TO OBTAIN A COPY, AND RIGHT TO CANCEL

I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to only release it to Amgen employees, as well as to its contractors and business partners, who are performing the services set forth in this Authorization. I also understand I am authorizing my personal information, including my *personal health information*, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to release my *personal health information* for the earlier of five (5) years or until my participation in the program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen at 1-805-313-5151, emailing privacyoffice@amgen.com, or by writing to Amgen Privacy Office, One Amgen Center Drive, MS 28-4-A, Thousand Oaks, California 91320. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my *personal health information* to Amgen on an authorized on-going basis, my cancellation with Amgen will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

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NO EFFECT ON TREATMENT

I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. Federal law (including HIPAA) requires a signed authorization in order for Amgen to collect this information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

INFORMATION RECEIVED FROM HEALTH CARE PROVIDERS

I understand that once my *personal health information* has been disclosed to Amgen, federal privacy laws may no longer apply and protect it from further disclosure. Amgen agrees, however, to protect my *personal health information* by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

AUTHORIZATION TO CONTACT

I understand and consent to Amgen contacting me using the contact information provided to Amgen or its contractors to enroll me in, operate, and administer Amgen patient support services and/or programs as described above other than promotional communications by telephone or SMS/text (which I can separately opt in, below). I understand that the operation and administration of certain of these services and/or programs may require that Amgen contact me by telephone or SMS/text.

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☐ **Telephone Consumer Protection Act (TCPA) Consent**

In addition to the above consent, I understand that by checking this box and signing below, I consent to Amgen calling and texting me at the phone number(s) I have provided with promotional communications relating to Amgen products and services and/or my condition or treatment. Amgen may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message (standard text messaging rates may apply). I understand that I am not required to provide this consent as a condition of purchasing any goods or services. Reply STOP to cancel SMS messages.

Name of participant

Name of legal guardian (if needed)

Signature of participant (or legal guardian) Date

ONCE THE PATIENT HAS READ AND SIGNED THIS AUTHORIZATION FORM, PLEASE FAX IT TO 1-866-406-6155.

PLEASE BE ADVISED THAT THE PATIENT'S AVSOLA™ CO-PAY CARD PROGRAM PRE-PAID MASTERCARD® WILL NOT BE FULLY ACTIVATED UNTIL AMGEN CONFIRMS RECEIPT OF A FAXED COPY OF THIS COMPLETED FORM.

Please see accompanying full Prescribing Information and Medication Guide for AVSOLA.

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FOR MORE INFORMATION, VISIT AVSOLASUPPORT.COM,
OR CALL 1-866-264-2778, MONDAY–FRIDAY, 9 AM TO 8 PM ET.