Patient Authorization

I give permission for my health care providers (HCPs), pharmacies, health insurer(s), third party contractors, and service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Sandoz, its affiliates, business partners, and agents (together "Sandoz") so that Sandoz can (i) help verify or coordinate insurance coverage or otherwise obtain payment for my treatment with HYRIMOZ, (ii) coordinate my receipt of and payment for HYRIMOZ, (iii) provide or facilitate my access to HYRIMOZ, (iv) provide me with information about HYRIMOZ, disease awareness, management programs, and educational materials, (v) manage the Sandoz One Source for HYRIMOZ program, (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with the Sandoz One Source for HYRIMOZ program, and (viii) to send me information about programs that might help me pay for my medicines, and to coordinate and share my Personal Information with my health care providers, other programs that might help me pay for medicines, government agencies, and insurance companies for purposes of providing or facilitating this assistance.

I give permission to Sandoz to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from Sandoz in exchange for disclosing my personal information to Sandoz and/or for providing me with therapy support services.

I understand that once my Personal Information is disclosed it may no longer be protected by federal and state privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to the Sandoz One Source for HYRIMOZ program at any time in the future by calling 1-833-497-4669.

My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; however, if I revoke this authorization, I may no longer be able to participate in the Sandoz One Source for HYRIMOZ program and/or programs administered

by Sandoz. If I revoke this authorization, Sandoz will stop using or sharing my information (except as necessary to end my participation in the program) but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature unless I revoke it earlier. I also understand that the Sandoz One Source for HYRIMOZ program and/or programs administered by Sandoz may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

I agree to be contacted by Sandoz by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Sandoz One Source for HYRIMOZ program form for all purposes described in this Patient Authorization. I also agree to be contacted by Sandoz, and others on its behalf by telephone calls and text messages made by or using an automatic telephone dialing system or prerecorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and I agree to notify Sandoz promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that Sandoz does not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Telephone Consumer Protection Act (TCPA) Consent: I consent to receive marketing and non-marketing calls and texts from and on behalf of Sandoz, made with an auto dialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections; average of 1-2 messages per week. Message and data rates may apply. Privacy Policy at https://www.us.sandoz.com/privacy-policy. Text STOP to opt out and HELP for help.

Sandoz Hyrimoz Co-pay Terms and Conditions: Limitations apply. Valid only for patients with private insurance and where not prohibited by law. Prescription must be for an approved indication. Program is subject to an annual limit, and the patient is responsible for any costs once limit is reached in a calendar year. Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, (iii) where the patient's insurance plan reimburses for the entire cost of the drug, or (iv) where product is not covered by patient's insurance. The value of this program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. Patient may not seek reimbursement for the value received from this program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. Patient is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the Program. Valid only in the United States and US Territories (Puerto Rico, American Samoa, Guam, Northern Mariana Islands, and US Virgin Islands). This Program is not health insurance,

and may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. Sandoz reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

Cordavis Hyrimoz Co-pay Terms and Conditions: Limitations apply. Valid only for those with private insurance. Prescription must be for an approved indication. Patient is responsible for any costs once limit is reached in a calendar year. Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, (iii) where the patient's insurance plan reimburses for the entire cost of the drug, or (iv) where product is not covered by patient's insurance. The value of this program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co payments, coinsurance, and deductibles. The Cordavis Hyrimoz Co-pay Terms and Conditions have restrictions when insurance entities limit what can be counted towards your deductible or other costs you bear when buying your medication. The most common names are "co-pay accumulator'' or "co-pay maximizer'' programs. These programs may be implemented without your awareness. In some cases, there may be a negative financial impact. The use of "co-pay accumulator'' or "co-pay maximizer'' programs by your insurer or health plan will limit your program benefits. These limits can be modified without prior notice. Cordavis reserves the right to audit and investigate any suspected violation of these terms and conditions. Cordavis also has the right to modify these terms and conditions at any time without prior notice. Program is not valid where prohibited by law. Patient may not seek reimbursement for the value received from this Program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. Patient is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the Program. Valid only in the United States and U.S. Territories (Puerto Rico, Guam, Northern Mariana Islands, and Virgin Islands). This Program is not health insurance. Program may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. Cordavis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

Fair Credit Reporting Act (FCRA) Authorization: I understand that I am providing "written instructions" authorizing the Sandoz One Source for HYRIMOZ program and its vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely for the purpose of determining financial qualifications for programs administered by Sandoz. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call the Sandoz One Source for HYRIMOZ program at 1-833-497-4669. If eligible, I would like to be considered for programs administered by Sandoz.

Sandoz Patient Assistance (SPA) Terms & Conditions: SPA provides free medicine to qualifying patients. Participation in our program is free. Medication assistance is dependent on your ability to meet the eligibility criteria for our program as determined by SPA. SPA does

not have any obligation to provide the program services to you and is not liable in the provision of these services. Patients with insurance plans or employers that require them to apply to a manufacturer's patient assistance program as a condition of, requirement for, or prerequisite to coverage of relevant Sandoz products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through SPA are not eligible for the SPA program. You agree to inform SPA if you are a member of such an insurance plan or if you are applying to SPA on behalf of a patient who is a member of such an insurance plan. The program may be changed or discontinued without notice. You will not seek reimbursement for any products dispensed under the program. You must notify the program if your insurance or financial situation changes. If you are a member of a Medicare plan including a Medicare Prescription Drug Plan and are qualified for program assistance, you will: (i) be eligible to obtain the medication from the program for a calendar year term (ii) not purchase this medication under your Medicare plan while enrolled in the program; (iii) not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during your enrollment. If you have questions, want to update your information, or terminate your enrollment, please call 1-833-4SANDOZ (1-833-472-6369).

☐ *I have read and agree to the Patient Authorization.

☐ I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) consent (optional).

☐ *I have read and agree to the Terms and Conditions for participation in the Co-Pay Assistance Program.

☐ *I have read and agree to the Sandoz Patient Assistance program (SPA) and Fair Credit Reporting Act Authorization.

Patient/Parent/Legal Guardian Signature:

*Name:

*Today's Date: 01/29/2025

BACK NEXT

Privacy Policy

Please see the full Prescribing Information, including Boxed Warning, and Medication Guide for HYRIMOZ (adalimumab-adaz).

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