JazzCares for ZEPZELCA™ Patient Authorization Form

Call Toll Free: 1-833-533-5299
Monday-Friday: 8:00 AM to 8:00 PM ET
Fax: 1-855-593-3955

Fax completed form to: 1-855-593-3955

For more information call: 1-833-533-5299

Please Print

Prescriber Name: _____

Patient Name: _____ Date of Birth: _____

Patient Authorization ("Authorization")

(SIGNATURE IS REQUIRED FOR PARTICIPATION IN JAZZCARES FOR ZEPZELCA)

I hereby authorize my prescriber(s) and their staff and my health insurer(s) to disclose my personal health information ("Personal Health Information" or "PHI") to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together "Jazz Pharmaceuticals") for the JazzCares ZEPZELCA Program (the "Program").

I understand and authorize Jazz Pharmaceuticals to use the PHI it receives as a result of this Authorization for the following purposes: (i) enrolling me in the Program; (ii) verifying, investigating, coordinating and resolving insurance coverage or reimbursement inquiries and payment for ZEPZELCA; (iii) coordinating my receipt of and payment for ZEPZELCA; (iv) contacting me about the Program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews); (v) contacting and providing my PHI to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment; (vi) de-identifying my PHI by aggregating it for research purposes, and (vii) managing the Program.

I understand and authorize Jazz Pharmaceuticals to contact me through a variety of means including email, postal mail, phone, or fax, unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below.

I understand Jazz Pharmaceuticals may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy any PHI about me Jazz Pharmaceuticals may create or receive.

I understand Jazz Pharmaceuticals will not disclose my Personal Information to a third-party that is not related to the Program (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my PHI, I understand the receiver may not be subject to HIPAA or other privacy laws and the PHI might be re-disclosed by the recipient and no longer protected by HIPAA or other privacy laws.

I understand I may refuse to sign this Authorization and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, and my health insurer(s). I also understand that if I revoke this Authorization, I may no longer be eligible to participate in the Program. I understand I may revoke this Authorization at any time in the future except to the extent Jazz Pharmaceuticals has already taken action in reliance on this Authorization and my future revocation will not affect the treatment I receive from my prescriber(s) and their staff, and my health insurer(s); but if I revoke this authorization I may no longer be eligible to participate in the Program.

Notwithstanding any applicable law to the contrary, this Authorization will remain valid for five (5) years after the date of my signature or such shorter time as may be required by state law, unless I revoke it earlier by calling 1-833-533-5299 or sending my request to: JazzCares ZEPZELCA Program, 6000 Park Lane, Pittsburgh, PA 15275. I also understand the Program may be changed or ended at any time without prior notification. I understand I may request a copy of this Authorization that is on file with Jazz.

I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Patient/Representative Signature:	Date of Signature:
Patient Representative's Name (if signing for patient):	
Relationship to Patient (spouse, legal guardian, etc.):	
Patient's Address:	
City: State: Zip Code:	
Home Phone: Cell Phone:	