

Guidance for JazzCares Patient Authorization Form

It is highly recommended that your patients enroll in JazzCares to access nursing and pharmacy support, financial assistance programs if eligible, and resources and support tools throughout their treatment journey. Click [here](#) for your patients to sign the Patient Authorization.

Patient Authorization

To submit this form, please complete all required fields below. Required fields are denoted by "*".

Patient Information

*First Name	*Last Name	*Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>
*Email	Phone	Cell Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

Insert patient's first and last name, date of birth, and email. Phone numbers are optional

Prescriber Information

*First Name	*Last Name
<input type="text"/>	<input type="text"/>

Enter prescriber's first and last name

Patient Authorization for Disclosure and Use of Health Information (SIGNATURE IS REQUIRED FOR PARTICIPATION in Jazz-sponsored patient support programs and activities)

I hereby authorize and direct my prescriber(s), their office staff, my health insurer(s), and the specialty pharmacy that will fill my prescription (the "Pharmacy"), to disclose my Health Information to Jazz Pharmaceuticals including its affiliates and services providers (together referred to as "Jazz Pharmaceuticals" or "Jazz") for any Jazz-sponsored patient support programs and activities, including the JazzCares program.

I consent to the collection, processing and disclosure of my Health Information for the purposes described in the [Patient Authorization Disclosure form](#).

I confirm that I have read, understood, and accepted the [Patient Authorization Disclosure form](#).

Consent to receive email communications from Jazz Pharmaceuticals about educational programs, products, and services

By checking this box, I confirm that I am 18 years of age or older and a resident of the U.S. I am indicating that I would like to receive information from Jazz about educational programs, products and services. I consent to the collection, processing and sharing of my Health Information, by Jazz, its affiliates and services providers to conduct marketing activities and to communicate with me regarding products and services that may be of interest to me. I understand that Jazz will not sell my Health Information to third parties. I can unsubscribe at any time from future email communications from Jazz by clicking the "unsubscribe" link provided in email communications from Jazz.

Link opens the detailed disclosure form pictured on the next page

Check this consent box for the patient to receive emails with information about JazzCares offerings

Consent to receive telephone communications from Jazz Pharmaceuticals (TCPA Consent)

By checking this box, I consent to Jazz calling and texting me at the phone number(s) provided with promotional communications relating to Jazz products and services and/or my condition or treatment (standard text messaging rates may apply). I can reply STOP to opt out at any time.

Check this consent box for Jazz to call or text the patient with important information about their prescription

I understand that I can withdraw consent from collection, use or sharing of my Health Information for marketing purposes at any time using one of the methods listed in the [US Consumer Health Data Privacy Policy](#).

I understand that participation in Jazz-sponsored patient support programs and activities, including the JazzCares program, is voluntary, and, if I have consented, receipt of marketing communications are optional services.

I understand that the consent(s) above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications.

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.

I agree to the use of electronic records and signatures. I acknowledge that I will have the option to download this document after hitting the submit button and the ability to save, or send this electronic record and disclosure to a location where I can print it, for future reference and access.

Use the mouse to create a digital signature in the black box. Click "Clear signature" to delete your signature and create a new one

[Clear signature](#)

Click "Submit" to finalize the information and submit the form

Patient Authorization for Disclosure and Use of Health Information (SIGNATURE IS REQUIRED FOR PARTICIPATION IN Jazz sponsored patient support programs and activities)



Click the "X" to close and return to the form

I. Uses and Disclosure of Health Information

I hereby authorize and direct my prescriber(s) and their staff, my health insurer(s) and the specialty pharmacy that will fill my prescription (the "Pharmacy"), to disclose my name (and the name of my caregiver if applicable), gender, date of birth, contact information and the following information (together "Health Information") to Jazz Pharmaceuticals (including its affiliates and services providers acting as data processors) (together "Jazz Pharmaceuticals" or "Jazz") for any Jazz-sponsored patient support programs and activities, including the JazzCares program:

- Information concerning my treatment with Jazz Pharmaceuticals' products, including relevant diagnoses and prescriptions; and
- Information about my health insurance benefits, including deductibles and out-of-pocket costs.

I understand and authorize Jazz Pharmaceuticals to use and further disclose my Health Information it receives as a result of this Form for the following purposes:

- operating, administering, enrolling me in, and/or continuing my participation in the JazzCares program or any other Jazz-affiliated patient support services and activities related to my condition or treatment;
- verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Jazz Pharmaceuticals' products;
- coordinating my receipt of and payment for Jazz Pharmaceuticals' products;
- contacting me about any Jazz-sponsored patient support programs and activities, including the JazzCares 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);
- contacting and providing my Health Information to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment;
- de-identifying my Health Information by aggregating it for research purposes;
- managing Jazz-sponsored patient support programs and activities, including the JazzCares program, and administrative purposes that support these services and programs.

I understand Jazz Pharmaceuticals will not sell my Health Information to third parties, but Jazz Pharmaceuticals may disclose such information to its affiliates and services providers for the purpose described in this Form. I also understand that if I do not consent to the use of my Health Information for the above purposes, I will not be able to participate in Jazz-sponsored patient support programs and activities, including the JazzCares program.

This Form will remain valid until termination of enrollment in Jazz-sponsored patient support programs and activities, including the JazzCares program, unless a shorter time is required by state law. I understand the Program may be changed or ended at any time without prior notification.

I understand I may request a copy of this Form that is on file with Jazz.

I also understand that I can withdraw my consent to the processing of my Health Information for the above purposes and revoke this Form at any time by calling 1-866-997-3688, emailing customer-care@jazzpharma.com or sending my request to: Jazz Pharmaceuticals, PO Box 66589, St. Louis, MO 63166-6589. If I do so, I will no longer be eligible to participate in Jazz-sponsored patient support programs and activities, including the JazzCares program.

I understand that should I revoke this Form, the revocation will not impact uses and disclosures of my Health Information that have already occurred in reliance on this Form.

More information on Jazz Pharmaceuticals' privacy practices

Further information concerning Jazz Pharmaceuticals' privacy practices can be found at <https://www.jazzpharma.com/privacy-statement/>. If you are a resident of California, a description of the Health information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found here: <https://www.jazzpharma.com/privacy-statement/supplemental-notice-for-california-consumers/>.

Close

Click "Close" to return to the form

✓ You have successfully completed the signing process.

Your document is complete and may be downloaded by clicking the button below.

Download Your Signed Patient Authorization Form >

Click "Download Your Signed Patient Authorization Form" to save a copy

Ask your patients to sign the JazzCares Patient Authorization now



FOR MORE INFORMATION

- Visit www.jazzcares.com or call 1-833-533-JAZZ (5299), Monday-Friday, 8 AM - 8 PM ET
- Contact your Jazz **Access and Reimbursement Manager**