JazzCares®
Making a difference in Patients' lives, one Patient at a time

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.

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

Enter prescriber's first and last name

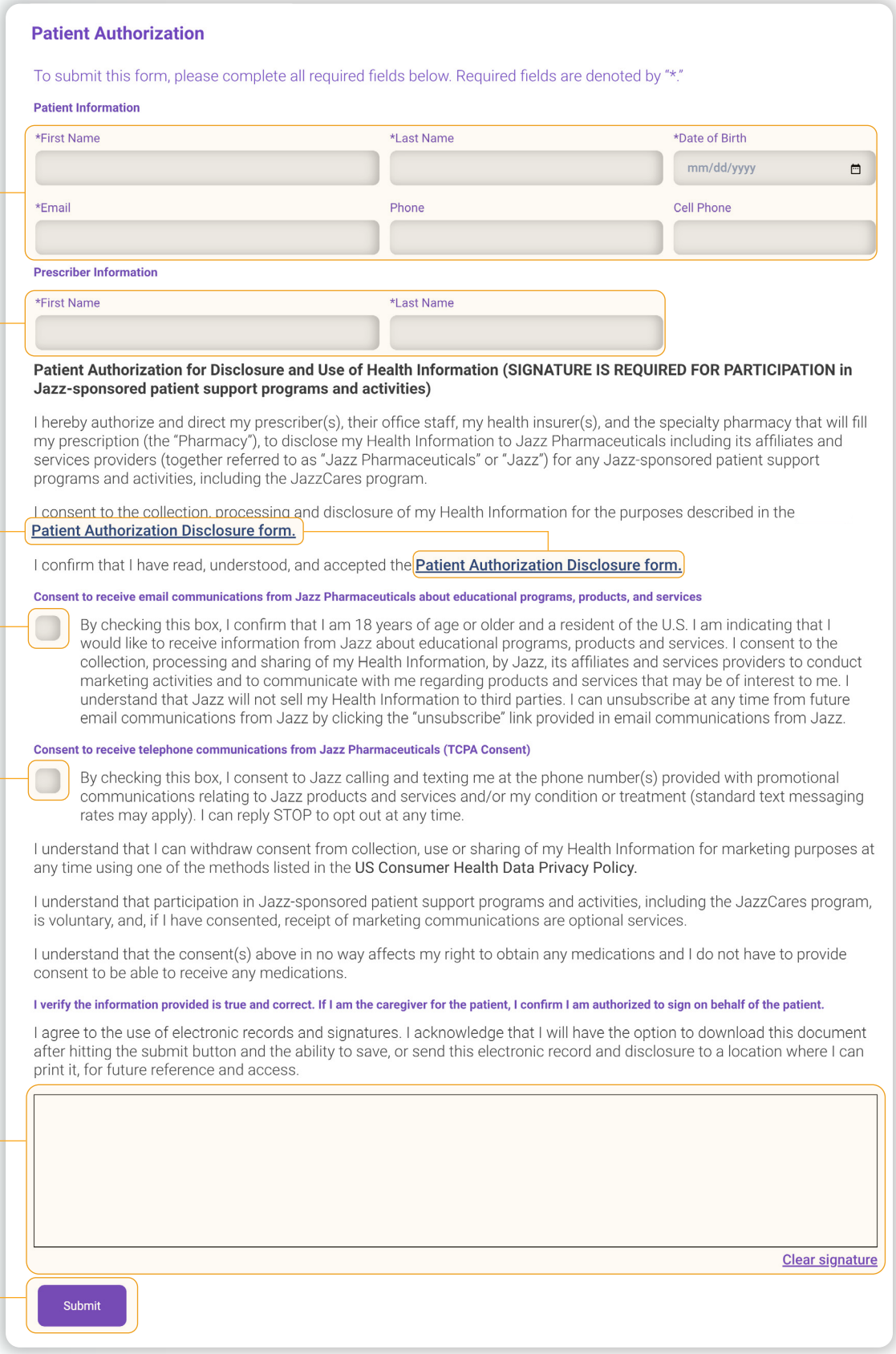
Link opens the detailed disclosure form pictured on the next page

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

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

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

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



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 (mm/dd/yyyy)

*Email | Phone | Cell Phone

Prescriber Information

*First Name | *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.

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.

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.

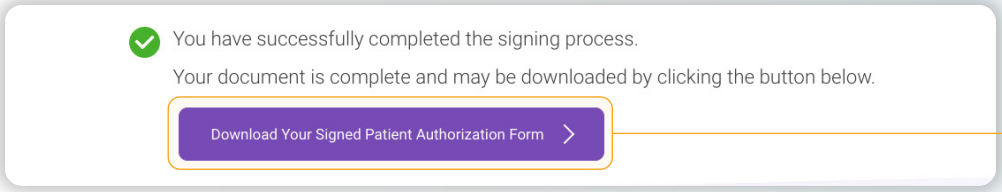
I agree to the use of electronic records and signatures. I acknowledge that I will have the option to download this document after hitting the submit button and the ability to save, or send this electronic record and disclosure to a location where I can print it, for future reference and access.

Clear signature

Submit

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

Click "Close" to return to the 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**

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Jazz Pharmaceuticals