PATIENT AUTHORIZATION FORM
FOR PYZCHIVA® (ustekinumab-ttwe)

Please read the following carefully, then check desired permission boxes and sign and date where indicated on page 2.

Please return the signed copy, either via mail with attention to: Sandoz One Source for PYZCHIVA at 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, or by fax at 1-844-422-5957.

Patient Authorization: I give permission for my health care providers, 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 PYZCHIVA, (ii) coordinate my receipt of and payment for PYZCHIVA, (iii) provide or facilitate my access to PYZCHIVA, (iv) provide me with information about PYZCHIVA, disease awareness, management programs, and educational materials, (v) manage the Sandoz One Source for PYZCHIVA program, (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with Sandoz One Source for PYZCHIVA 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 Health Information (PHI) to my healthcare 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 healthcare 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 PHI 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 PYZCHIVA program at any time in the future by calling 1-855-SANDOZ-8 (1-855-726-3698). 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 PYZCHIVA 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 PHI previously disclosed in reliance upon this authorization.

I understand that this authorization will expire upon the earlier of (i) five (5) years from the date of my signature, (ii) until I revoke it, or (iii) as may be required by applicable state law.

I understand that I may receive a copy of this authorization. I also understand that the Sandoz One Source for PYZCHIVA program and/or programs administered by Sandoz may change or end at any time without prior notification. I agree to be contacted by Sandoz by mail, e-mails, telephone calls, and text messages at the number(s) and address(es) provided on the Sandoz One Source for PYZCHIVA program form for all purposes described in this Patient Authorization.

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 autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. The number of messages will vary based on your program selections; an average of 1-2 messages are sent per week. Message and data rates may apply. Review our Privacy Policy at https://www.us.sandoz.com/privacy-policy. Text STOP to opt out and HELP for help. 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.

Sandoz One Source Co-Pay Program for PYZCHIVA: Limitations apply. Valid only for those with private commercial insurance. Prescription must be for an approved indication. Restrictions, including monthly and/or annual maximums may apply. Patient is responsible for any costs once program limit is reached. Program not valid (i) if prescription for PYZCHIVA is paid, in whole or in part, under Medicare (including Part D, even in the coverage gap), Medicaid, Medigap, 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. It is a violation of the terms and conditions of this program to use it to enroll patients for the purposes of a copay accumulator or maximizer program. Sandoz reserves the right to take any appropriate action against any person or entity using the program in violation of the terms and conditions. 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 US 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. Co-pay program has no cash value. Additional terms and conditions may apply. Sandoz 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 PYZCHIVA 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 PYZCHIVA program at 1-855-SANDOZ-8 (1-855-726-3698). If eligible, I would like to be considered for programs administered by Sandoz.

○ **I have read and agree to the Patient Authorization on page 1.**

○ **I have read and agree to the Terms and Conditions for participation in the Sandoz Co-Pay Assistance Program on pages 1 and 2.**

○ **(optional) I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) consent on page 1.**

○ **I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization on page 2.**

Patient/Legal Guardian Name (print) ______________________________

Patient/Legal Guardian Signature ______________________________

Date of Service ____________________

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