Patient Full Name*	Date of Birth*

Patient Authorization for Use and Disclosure of Personal Health Information (PHI)

I understand that I must complete this enrollment form before I can receive assistance through Cycle Pharmaceuticals Ltd and the Cycle Vita™ Support Program. I understand that the Cycle Vita Support Program is only applicable for medication marketed by Cycle Pharmaceuticals Ltd and administered through the Cycle Vita Support Program. As part of this process, personnel from Cycle Pharmaceuticals Ltd, or the Cycle Vita Support Program and their agents and contractors (collectively, "Cycle") will need to obtain, review, use and disclose PHI as described below. To ensure I have access to the benefits afforded by the Cycle Vita Support Program for which I may qualify AND to ensure my Personal Health Information (PHI) is appropriately protected in compliance with applicable federal laws and regulations:

- I further authorize my healthcare providers (HCPs) and health plans to disclose my PHI as described below to an authorized Cycle Health Care Professional (HCP) in connection with the Cycle Vita Support Program and I authorize Cycle to use and disclose the information for the purposes stated in this authorization.
    1. Information to Be Disclosed: Personal health information (PHI), including information about me (for example, name, mailing address, financial information, and insurance), my past, current and future medical condition and information provided on this form to include information concerning Adverse Events (AE).
    2. Persons Authorized to Disclose My Information: My HCPs, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me healthcare benefits.
    3. Persons to Whom My Information May Be Disclosed: A qualified HCP, a nurse, Cycle employees, individuals representing Cycle, including any third-party administrators responsible for the administration of the Cycle Vita Support Program, appropriate third parties under contract to Cycle, such as the Cycle Pharmacovigilance Agency and product manufacturer(s), to properly address any reports Adverse Events (AEs) related to Cycle's medication. I understand my PHI will only be shared in accordance with my consent as described within this form.
    4. Purposes for Which the Disclosures Are to Be Made: Disclosures of PHI may be made to Cycle so that Cycle may use and disclose the PHI for purposes of completing the Cycle Vita Support Program enrollment process, verifying my enrollment form and establishing my eligibility for the Cycle Vita Support Program and associated benefits that may include:
        a. Insurance and Reimbursement Assistance: Authorization allows for professional assistance at no charge on Patient's behalf for Claims Settlement, Claims Submission to health insurers, and communication of relevant claim information to/from HCPs and Insurance carriers.
        b. Reimbursement Support: Financial Assistance, including Cycle's sponsored Co-Pay Assistance program, available only for eligible patients.
        c. Patient Benefits Investigation & Payer Prior-Authorization Support: personnel from the Cycle Vita Support Program will contact, investigate, and arrange for Patient's eligible coverage with their respective Health Insurer and/or PBM (Pharmacy Benefit Manager) including assistance with Prior-Authorizations.
        d. Patient Education and Information: Personnel from the Cycle Vita Support Program will provide Patients with full education on medication storage, administration, timely, relevant disease information and product information updates.
        e. Access to Manufacturer / Cycle: This will allow Cycle to alert Patients receiving Cycle's medication about relevant product and market updates, product recalls, Adverse Event notifications, and available resources, including adherence tools and other programs to ensure medication compliance.
        f. Product and Service Development: I understand and agree that any information that I provide or is disclosed to Cycle may be used by Cycle to help develop new products, services and programs. I further understand that Cycle will not sell my personal data to any unrelated third party for marketing purposes without my express permission.

Patient Full Name*	Date of Birth*

5. Limits of Protections after Disclosure. I understand that once my PHI has been disclosed hereunder, State or federal privacy law may no longer restrict its use or disclosure.
6. Option to Refuse. I understand I am not required to sign this Authorization as a condition to receive treatment with Cycle's products, or payment for health care; enrolling in a health plan; or establishing eligibility for benefits. However, by refusing to authorize disclosure of my PHI to a qualified and authorized Cycle HCP, I also understand that I am knowingly foregoing possible access to the benefits offered by the Cycle Vita Support Program.
7. Copy of Authorization and Ability to Cancel Authorization. I understand I will be given a copy of this Authorization after I sign it and my Authorization shall remain in effect until it expires (5 years from the date sign below unless a shorter period is required by the law of my state residence), or unless I revoke Authorization at any time by contacting personnel from the Cycle Vita Support Program at 888-360-8482 (VITA), Monday through Friday, from 8:00am to 8:00pm EST, by FAX, at 888-385-8482 (VITA) or in writing to Cycle Pharmaceuticals Ltd, 200 Portland St., Boston, MA 02114, USA
8. I understand that my pharmacy, health insurers and third-party vendors may receive payment from Cycle as the manufacturer in exchange for securely sharing my PHI to an authorized Cycle's HCP for the sole purpose of providing me access to important patient support as described above.

PATIENT AUTHORIZATION

I have read and understood the Patient Authorization Information and by signing this form authorize the use and disclosure of my personal health information as described above.

***Signature NOT required to begin benefit investigation. Authorization may also be collected verbally upon completion of benefit investigation with Cycle Vita.**

Patient Name (Printed)

Signature of Patient

Date

Signature of Patient Representative*

Date

*If signed by Patient Representative, please explain authority / relation to act on behalf of patient:

Please read the following statement and mark the box:

☐ By checking this box I hereby authorize the Cycle Vita Support Program to use my PHI to contact me by mail, e-mail, text, phone, or any communication method I request for the purposes as described herein.