Patient Authorization Form

AstraZeneca medicine: WAINUA

WAINUA™ (eplontersen) 45 mg injection for subcutaneous use

AstraZeneca Access 360™

Patient Information

First Name: _____ Last Name: _____ DOB: ____/____/____

Street: _____ City: _____

State: _____ ZIP Code: _____ Home Phone #: _____ Mobile Phone #: _____

Email: _____

I authorize my health care providers ("HCPs"), my health plan, and my pharmacies, and each of their respective agents, to use and share my Protected Health Information (my "Information") with AstraZeneca and Ionis Pharmaceuticals (including AstraZeneca US Patient Support and Ionis Patient Services) ("AZ/Ionis") and their affiliates, agents, and contractors. My Information includes my prescription-related health records, information about my health care plan benefits, demographic, contact, and any other information bearing on my health. My Information may be used to verify treatment and payment decisions with my HCPs; investigate and assist with coordination of coverage for WAINUA™ (eplontersen); coordinate prescription fulfillment and financial assistance; coordinate the provision of patient educational support and perform internal analysis at AZ/Ionis to better meet patient needs. I understand and agree that AZ/Ionis may contact me, including by mail, email, telephone and text. I understand that federal privacy laws may not protect my Information once it is disclosed; however, AZ/Ionis agrees to protect my Information by using and disclosing it only for the purposes specified herein. I understand that I can refuse to sign this Authorization and that my refusal will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. However, if I do not sign this Authorization, I will not be able to receive AZ US Patient Support/ Ionis Patient Services support. I understand that I may cancel this Authorization at any time by calling 1-800-236-9933 or by mailing a letter requesting such cancellation to AstraZeneca US Patient Support at One MedImmune Way, Gaithersburg, MD 20878. I understand that any such cancellation will not apply to any Information already used or disclosed based on this Authorization prior to AZ/Ionis's receipt of the cancellation. This Authorization expires two (2) years from the date signed below, unless a shorter period is required by state law.

Which best describes you? ☐ I am a patient ☐ I am a legally authorized representative Relationship to patient: _____

Communication preference: ☐ Email ☐ Text ☐ Both

Print Patient Name/Legally Authorized Representative Name

_____

Signature of Patient/Legally Authorized Representative

SIGN HERE _____ **Date:** ____/____/____

WAINUA Support Authorization (Savings Program and Additional Support)

By signing above, I understand that I may receive from AZ/Ionis or their agents, on an ongoing basis, information and support related to my condition and/or therapy including, but not limited to, educational and promotional materials, special offers, and support services. I further understand that I may be contacted by AZ/Ionis or their agents, on an ongoing basis, for market research purposes, including for the purpose of participating in focus groups, surveys, or interviews. I consent to receive marketing and non-marketing communications, including by mail, telephone, email and/or text message from AZ/Ionis or their agents, whether or not made with an auto-dialer or prerecorded voice, at the phone number(s) provided. Message and data rates may apply. My Information may also be used to perform internal analysis at AZ/Ionis. I understand that I can refuse to provide this Authorization and that this will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. I understand that my consent is not required, and is not a condition of purchase. I understand that I may cancel this Authorization at any time by calling 1-800-236-9933 or by mailing a letter requesting such cancellation to AstraZeneca Access Services at One MedImmune Way, Gaithersburg, MD 20878. Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition. AZ/Ionis will not knowingly collect, use, or disclose personally identifiable information from a minor under the age of 18. If you are under the age of 18, please have your parent, guardian, or healthcare provider request the information on your behalf. Please visit www.globalprivacy.astrazeneca.com to review our Privacy Notice.

☐ Yes, I would like additional information

Once completed and signed, fax this form to 1-844-329-2360. You may need to provide additional information depending on the type of support requested.

1-844-2-WAINUA (1-844-292-4682) **1-844-FAX-A360** (1-844-329-2360) **www.MyAccess360.com**

Access360@AstraZeneca.com **One MedImmune Way,** Gaithersburg, MD 20878

AstraZeneca IONIS A Genetic Medicines Company