PATIENT AUTHORIZATION FORM FOR RADICAVA™ (edaravone) IV infusion

## Instructions:

- **If patient has not already signed a Searchlight Support™ Benefit Investigation and Enrollment Form for RADICAVA™ (edaravone) IV infusion, patient must read this Patient Authorization and sign on the next page to authorize Searchlight Support™ services.**
- **Patient should retain a copy of this form for their records.**

My signature on this Patient Authorization Form (the "Form") serves as confirmation that I authorize each of my physicians and pharmacists, including any specialty pharmacy which receives my prescription for RADICAVA™ and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to use and disclose my Protected Health Information, including but not limited to medical records and history, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to MT Pharma America, Inc., its affiliated companies, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access and assistance programs for Healthcare Providers and patients (Searchlight Support™) (together, "MT Pharma America, Inc.") for the purposes described below.

I specifically authorize MT Pharma America, Inc., to receive, use, and disclose my Protected Health Information for the following purposes: (i) to enroll me in, and contact me and/or the person legally authorized to sign on my behalf, about Searchlight Support™ programs, including potential enrollment in the Searchlight Support™ Out-of-Pocket Assistance Program if I am an eligible, commercially insured patient with insurance coverage for RADICAVA™, the Searchlight Support™ Connect Program if I am an eligible, commercially insured patient when there is a delay in securing commercial health plan coverage for RADICAVA™ or Searchlight Support™ Patient Assistance Program, if I have no insurance, or no insurance coverage for RADICAVA™ and meet eligibility requirements; (ii) to provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to RADICAVA™; (iii) to verify, investigate, assist with, and coordinate my coverage for RADICAVA™ with my Insurers; (iv) to coordinate prescription fulfillment, including triaging my information and my prescription to a specialty pharmacy; and (v) to assist with analyses related to the quality, efficacy, and safety of RADICAVA™, and patient access to and treatment compliance with RADICAVA™. I understand that pharmacies that ship my medication may be paid to share this information with Searchlight Support™ in order to help provide the offerings requested for me. I also understand that my Protected Health Information will not be used or disclosed by MT Pharma America, Inc., for any other purpose than described in this Form unless permitted by law or unless information that specifically identifies me is removed and therefore "de-identified." I understand that MT Pharma America, Inc., will make every effort to keep my information private. I understand that information used or disclosed under this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law. For additional information on how MT Pharma America, Inc., collects, uses, and discloses personal information, visit www.mt-pharma-america.com/privacy-policy.

If I am eligible to participate in the Searchlight Support™ Patient Assistance Program (the "Program"), I understand that upon receiving health plan coverage for RADICAVA™, I will no longer be eligible to participate in the Program and that Searchlight Support™ Patient Assistance Program medication will no longer be dispensed to me. My eligibility to receive assistance in the Program will be reviewed every 12 months and may change if I no longer meet the current program eligibility requirements. For program eligibility requirements, terms and conditions, refer to the Searchlight Support™ Patient Assistance Program brochure. Additionally, I acknowledge and agree that I will not seek credit for or otherwise submit any claim for reimbursement to any third-party payer the RADICAVA™ medication provided at no charge by the Program. I understand and agree that the Program covers only the cost of RADICAVA™ and not the cost of any infusion services or Healthcare Provider visits, which are my sole responsibility. I understand that Searchlight Support™ has the right to verify my eligibility, including the right to audit any information provided on the next page, and to contact me to confirm receipt of medications. I also understand that the Program may be revised, changed or terminated at any time without notice.

I understand that I am not required to sign this Patient Authorization Form for RADICAVA™. My decision whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I do not sign below, or cancel (revoke) my Authorization later, I understand that this means I will not be able to participate or receive assistance from Searchlight Support™.

This Authorization will remain in effect for 5 years from the date of my signature, or until I am no longer participating in Searchlight Support™ services, whichever is sooner. I may cancel this Authorization at any time in writing by mailing a letter to Searchlight Support™, P.O. Box 2930, Phoenix, AZ 85062. I can also cancel my Authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with MT Pharma America, Inc., but this will not affect the ability of MT Pharma America, Inc., to use and disclose Protected Health Information that it has received prior to receipt of the cancellation of my Authorization. My Authorization will also end if Searchlight Support™ is discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to MT Pharma America, Inc.

Patient name: _____ Date of Birth (mm/dd/yyyy): _____

Patient address: _____

City: _____ State: _____ ZIP Code: _____

I have read this Form and understand that signing this Authorization is voluntary. By signing below, I acknowledge that I have read, understood and accept all of the above.

Patient signature: _____ Date: _____

If the patient cannot sign, patient's legally authorized guardian/caregiver must sign below:

By: _____ Date: _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

**Fax completed form to 888-782-6157 or mail to**
**Searchlight Support™, P.O. Box 2930, Phoenix, AZ 85062**

**Please see full Prescribing Information, including Patient Information, available at www.radicava.com.**