Patient Enrollment and Authorization Form

Phone: 1-866- AKCEATX (1-866-252-3289) **Fax:** 1-866-AKCEAFX (1-866-252-3239)
Email: AkceaConnect@akceatx.com

Patient Support and Experience Services is available to provide essential support, regardless of the management plan you and your physician choose.

Patient Support and Experience Services is a complimentary program offered by Akcea Therapeutics that is staffed by nurse case managers, who are registered nurses with clinical knowledge and funding expertise.

Patient Support and Experience nurse case managers provide ongoing support in the following areas:

- **Coverage issues and funding options:** Assisting patients with insurance coverage questions and research funding options
- **Education:** Collaborating with your healthcare team to answer questions and provide educational materials related to your disease
- **Management support:** Assisting with solutions for balancing all aspects of disease management when faced with major life challenges

In order to participate in the patient support program (PSP) and receive these patient services, PSP needs to receive, use, and share your personal health information. In this Form, we are asking you to agree to let your healthcare providers, health plan, or health insurers release your health information (sometimes called "Protected Health Information" or "PHI") to PSP and to allow PSP and its agents to use and share your PHI.

The PHI we need includes medical records regarding your medical condition and treatment, information about how well you are able to manage your treatment plan, information about your insurance coverage and benefits, and identifying information about you (including your name, address, date of birth, and Social Security number). PSP will only use this PHI in the ways described in this Form or as otherwise permitted by law.

You do not have to sign this Form and, if you choose not to sign it, your ability to obtain treatment from your healthcare providers and your eligibility for benefits under your health plan will not be affected. However, if you do not sign this Form, PSP may not be able to provide you with the services listed above.

To enroll in the PSP program for personalized support, please read the information on the back page and fill out, sign, and date the Form. Please read this Form carefully and contact PSP if you have any questions.

PATIENT INFORMATION

First Name:_____ Last Name: _____

Date of Birth:_____/_____/_____ Gender: _____ Last four digits of SS#: XXX-XX-_____

Street Address: _____ City:_____State:_____ZIP:_____

Telephone Number(s) of Patient (or Designated Representative, if applicable):_____

Email of Patient (or Designated Representative) (optional):_____

Designated Representative (Please fill out this section ONLY if the person signing this Authorization is not the Patient)

Name of Person Authorizing Release:_____ Relationship to Patient:_____

Additional Permissions (optional)

Name:_____ Relationship to Patient:_____

Telephone: _____Cell Phone: _____ Email:_____

Authorization to Receive Patient Services and Communications

I (or my representative) authorize Akcea Therapeutics, including, but not limited to, its affiliates, business partners, employees, sub-contractors, agents, and other representatives (together, "Akcea") to provide me with patient support services related to any of Akcea's products including, but not limited to, online support, financial assistance services, compliance and persistency services, and other therapy support services, as well as any Information or materials related to such services.

I (or my representative) agree and acknowledge that any Akcea personnel providing such support services are not employed by my healthcare professional, nor are providing medical treatment or advice.

Authorization to Use and Disclose Protected Health Information

I (or my representative) agree to permit the Authorized Parties listed below to disclose my Protected Health Information ("PHI") to Akcea Therapeutics, for the uses described below.

The Authorized Parties include:

1. My primary care physician, evaluating and/or treating physician, and any specialist or other healthcare providers involved in my treatment ("Providers");
2. The distributor, pharmacy, or home health agency that dispenses my medical therapy ("Distributors"); or (3) my health insurer, payer, or patient assistance program ("Payers") and (4) Laboratory.

The PHI that may be disclosed includes medical reports, orders, prescriptions and records, histories, findings, prognoses, plans of care and discharge summaries, billing information, insurance claims, utilization review reports and laboratory testing results.

The **Authorized Parties** may disclose my PHI to Akcea, so that Akcea may use and disclose the PHI for the following purposes:

1. **Coordination of care:** Between me, the Providers, Distributors, or Payers for the coordination of my medical care, including therapy adherence reminders.
2. **Disease management/patient education:** To provide information, training and case management services to me (or my representative), and any Providers, Payers, and Distributors.
3. **Clinical research/treatment protocols:** To inform me (or my representative) of clinical research studies, treatment protocols, or disease-related surveys that may benefit me.
4. **Reviewing insurance benefits/plan and/or funding options:** To review, co-verify, and to assist me (or my representative) in understanding the benefits provided by my Payer, to verify what services my benefits cover and help me obtain the services ordered by my Provider, to coordinate benefits, to determine appeal requirements, and to identify other sources of payment, if necessary.
5. **Billing and payment:** To coordinate the preparation, filing, and processing of health insurance claims, the evaluation of coding (billing) issues, and assist with the resolution of any claims issues relating to my therapy.
6. **Distribution of therapy:** To coordinate the distribution of medical therapy to me.
7. **Product orders:** To fulfill any product orders and answer any questions that I (or my representative) may provide to the Akcea case management team, and otherwise to inform me (or my representative) about other services that may be of interest to me (or my representative).
8. **Government agencies:** To provide information as required or requested by representatives of government agencies, review boards, and others who watch over the safety of drugs (or operations) of pharmaceutical manufacturers.
9. **Other uses of PHI:** To de-identify the information about me and to use this de-identified information in performing patient and community education, clinical protocol development, marketing studies, or for other commercial purposes as determined by Akcea.
10. **Contact:** To contact me (or my representative) by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system), and other mutually agreed-upon means.

Notice

I (or my representative) understand that once my PHI has been disclosed to Akcea, federal privacy laws may no longer protect it from further disclosure.

However, Akcea agrees to protect my PHI by using and disclosing it only for the purposes described in this Authorization or as permitted by law. **I understand that I do not have to sign this Authorization and that if I do not sign this Authorization, or choose to revoke it, my ability to obtain medical care and/or therapy, or my eligibility or enrollment for insurance benefits will not be affected. However, if I do not sign this Authorization, Akcea may not be able to provide the services described above.**

Signature

I (or my representative) have read and understand the terms of this Authorization Form. This Authorization shall be in effect for 10 years from the date of my signature, or the date of last enrollment, whichever comes first, unless a shorter period is required by law. I (or my representative) may revoke this Authorization at any time by sending a written letter which includes my name and address, to Akcea Therapeutics at the address or fax on the top of this form. I (or my representative) have the right to receive a copy of this Authorization upon request. I understand that my healthcare providers, insurers, and health plans may receive remuneration (payment) from Akcea in exchange for disclosing My Health Information to Akcea.

Signature of Patient or Designee:

X_____

Date:_____

Fax completed form to 1-866-AKCEAFX (1-866-252-3239) or

Email completed form to AkceaConnect@akceatx.com