SYNAGIS®
PALIVIZUMAB

# SYNAGIS Patient Consent Form

SYNAGIS CONNECT is an optional program provided by Sobi for patients and their parents, guardians, and providers that can help you understand your coverage and financial obligation for SYNAGIS and provide resources to help with treatment and payment for treatment. SYNAGIS CONNECT representatives can answer questions related to prescription coverage, out-of-pocket costs, and pharmacy options; affordability programs (based on eligibility); and claims and appeal process support.

**Parent/guardian should complete this form legibly and sign it. All completed forms should be faxed to 1-800-201-4938 or emailed to synagisconnect@rxallcare.com.**

## PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ HUB # (if known):_____

## PRIMARY CARE PROVIDER/SPECIALIST INFORMATION

Primary Care Provider/Specialist Name:_____

Address:_____ City/State:_____ ZIP:_____

Phone #:_____ Fax #:_____

## AUTHORIZATION

By signing this Authorization, I authorize healthcare providers, insurance companies or pharmacies to disclose in electronic or other forms the patient's personal and protected health information, including address, medical records, and prescription and insurance information, to or by the following: Sobi, Inc. and its subsidiaries and affiliates, contractors, employees, agents and successors (collectively, "Sobi").

Sobi will provide support services, including insurance and reimbursement assistance. Such authorization allows for support in the receipt of treatment; claims settlement; submission of claims to health insurers for payment; communication of information to the physician, other healthcare providers, and insurance carriers; reimbursement services; eligibility for any financial assistance; and administration of SYNAGIS® (palivizumab). I also authorize and understand that Sobi and healthcare providers involved in the patient's care may use and disclose protected health information for quality assurance purposes, including but not limited to quality assurance reviews. SYNAGIS CONNECT is authorized to contact me by mail, e-mail, text, telephone, and/or any alternative communication method that I request for the purposes as described herein.

I understand that third parties may receive payment from Sobi or those acting on behalf of Sobi in exchange for disclosing protected health information to Sobi and/or for providing me with support services, including sending communications to me, for purposes of the SYNAGIS CONNECT program as defined herein.

I understand that I am not required to sign this Authorization as a condition to receiving treatment with Sobi's products or payment for healthcare; enrolling in a health plan; or establishing eligibility for benefits. I understand that I am entitled to keep a copy of this Authorization after I sign it.

I understand that this authorization shall remain in effect until it expires, unless I revoke it sooner. I may revoke this Authorization at any time by contacting SYNAGIS CONNECT by phone at 1-866-285-8419 or in writing at AllCare Plus Pharmacy, 50 Bearfoot Rd, Northborough, MA 01532, Attn: SYNAGIS CONNECT. I understand that the revocation will be effective upon actual receipt of my letter by SYNAGIS CONNECT at the above address. If I do withdraw the authorization, it can no longer be relied upon to make uses and disclosures of the patient's protected health information, but that will not invalidate uses and disclosures already made in reliance upon this authorization. I understand that the protected health information released based on this Authorization may be subject to redisclosure by Sobi, and therefore may no longer be protected by certain federal privacy regulations, but Sobi plans to use and disclose the information only as described within this authorization.

This Authorization expires two (2) years (or such lesser time as state law may require) from the date this Authorization is signed.

**Which best describes you?**

○ I am a parent ○ I am a legal guardian Relationship to patient:_____

Full name (printed) of parent/guardian_____

*SIGN HERE* **Signature of parent/guardian**_____ **Date**_____


PP-6293 US-30225 6/19

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