BioMarin RareConnections™ Patient Enrollment Form for CLN2 Disease

Fax completed form to **1-888-863-3361**
or email to **support@biomarin-rareconnections.com**
Phone: 1-866-906-6100 Hours: M–F 6 AM–5 PM (PST)

PATIENT

First name _____ Last name _____ Birth date _____ Gender ☐ Male ☐ Female

Parent/Caregiver name _____

Home address _____ Suite/Apt _____

City _____ State _____ ZIP _____

Home address _____ Suite/Apt _____

City _____ State _____ ZIP _____

Home phone _____ Work phone _____ Cell phone _____

Email _____ Preferred method of contact ☐ Home ☐ Work ☐ Cell ☐ Email

Preferred language ☐ English ☐ Other _____

I authorize BioMarin RareConnections™ to leave a message if I am not available ☐ Yes ☐ No

Has your child been diagnosed with CLN2 disease? ☐ Yes ☐ No

Patient/Caregiver signature _____ Date _____

PHYSICIAN

Physician overseeing your child's CLN2 disease care

First name _____ Last name _____ Specialty _____

Name of institution/Practice name _____

Street address _____ Suite _____

City _____ State _____ ZIP _____

Office contact _____ Phone _____ Fax _____

Is there another physician expert you've consulted with regarding your child's CLN2 disease management? ☐ Yes ☐ No

If yes, please provide the information below

Name of institution _____

Physician name _____

Physician specialty _____

INSURANCE

Primary insurance name _____

Insurance phone number _____

Policyholder name _____

Relationship to patient _____

Group ID _____

Employer _____

Member ID (policy) number _____

Secondary insurance name _____

Insurance phone number _____

Policyholder name _____

Relationship to patient _____

Group ID _____

Employer _____

Member ID (policy) number _____

Provide copies of all medical and prescription cards—front and back, primary and supplemental coverage.

☐ Patient does not have insurance

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Authorization for Disclosure of Protected Health Information by Healthcare Providers and Health Insurers
(Provider Authorization)

Authorization for Use and Disclosure of Protected Health Information by BioMarin
(BioMarin Authorization)

Request to Provide Access to Laboratory Reports to BioMarin
(Genetic Information)

Frequently Asked Questions

Why do I have to sign these forms?

In order for BioMarin to assist with its medicines and related care, you will need to provide consent to both your healthcare provider and BioMarin:

- Your healthcare provider needs your written consent to release your protected health information (PHI) to BioMarin.
- BioMarin also needs your written consent to share your information (including genetic information) with other providers to assist you with accessing services that support your treatment.

Once you give consent, your healthcare provider will provide BioMarin with the information from your medical records needed to enroll you in BioMarin RareConnections™. BioMarin RareConnections will help you work with your insurance provider to try to help you get reimbursement for your care and will help you with other case management services.

What are the benefits of checking the boxes?

By checking the boxes, you can choose to receive educational information from BioMarin about your condition, get help organizing additional services that support your treatment plan, and have an opportunity to provide feedback to BioMarin through market research.

How will BioMarin utilize my PHI to assist me?

BioMarin will use your PHI to enroll you in BioMarin RareConnections, which provides a number of case management services that help support your treatment plan (for example, to remind you of appointments or medicine schedules). BioMarin RareConnections will work with you, your healthcare provider, and your health insurance company to help with coverage related to your treatment. If you do not already have insurance coverage, BioMarin RareConnections can help you find it.

Who signs the forms?

For patients under the age of 18, your parent or guardian signs the authorization forms on your behalf. For adult patients (18 years and older), you (or your guardian as appropriate) sign the forms.

Patients are required to sign the authorization forms when they turn 18 years old, unless they have a legal guardian, in which case the patient's guardian would sign the forms.

Where will these forms be kept?

These forms will be kept on file at BioMarin RareConnections. It is also recommended that these forms be kept with your medical records at your healthcare provider's office.

Can I cancel my authorization?

Yes, at any time. You just need to fax a signed letter to BioMarin at **1.888.863.3361**, or email your request to support@biomarin-rareconnections.com. You can also mail a signed letter to BioMarin at 2001 Broadway, Suite 200, Oakland, CA 94612. This will stop BioMarin from making any further use of your information for any of the reasons described above.

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Authorization for Disclosure of Protected Health Information by Healthcare Providers and Health Insurers

This Authorization allows my healthcare providers, health plans, and health insurers to disclose my protected health information (PHI), including medical records, genetic information, and financial and insurance coverage information, to BioMarin Pharmaceutical Inc. and its agents, contractors, and assignees (collectively "BioMarin") for the purposes described below.

Specifically, by signing this Authorization, I authorize my healthcare providers, health plans, and health insurers to disclose such of my PHI (for example, my name, address, policy number, and dates of treatment) as BioMarin may request in order to:

- enroll me in, and contact me about, BioMarin RareConnections™
- provide case management, including supporting my treatment, such as through telephone or electronic communications to assist with adherence to my medication regimen
- work with my insurance carrier and other potential funding sources to try to help me get coverage, reimbursement, or payment for BioMarin products
- work with third parties to provide testing for screening, diagnostic, and monitoring purposes, as well as related services (e.g., genetic test interpretation)

BioMarin may also further use and disclose my PHI as required or permitted by law, or as I may authorize. I understand that, once my PHI has been disclosed to BioMarin, federal privacy laws may no longer protect the information.

I understand that I do not have to sign this Authorization. If I do not sign, my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected. However, if I do not sign, I will not be eligible to receive services from BioMarin.

I also understand that I may cancel this Authorization at any time by faxing a signed letter to BioMarin at the number listed to the right. Canceling this Authorization will stop my healthcare providers and health insurers from making further disclosures of my PHI to BioMarin, as described above, after the date that my letter is received and processed. However, canceling this Authorization will not affect BioMarin's ability to use and disclose PHI that it has already received (unless the laws of my state prohibit BioMarin from continuing to use or disclose such PHI).

This Authorization will expire 10 years after the date that I sign this form. I understand that I will receive a copy of this signed Authorization upon request from BioMarin Pharmaceutical Inc.

Provider Authorization

I have read and understand the terms of this Authorization. By signing this form, I knowingly and voluntarily authorize the disclosure of my PHI (including genetic information) as described earlier on this form. I agree that a copy of this form may be treated as a signed original.

Patient/Authorized Representative Signature

Date

Print Patient's Name

Print Authorized Representative's Name (if applicable)

Relationship to Patient

Please fax completed form to **1.888.863.3361** or email to support@biomarin-rareconnections.com. Provide a copy of this form to the patient and place the original in the patient's medical record.

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BIOMARIN®

Authorization for Use and Disclosure of Protected Health Information by BioMarin

By signing this Authorization, I agree to allow BioMarin Pharmaceutical Inc. and its agents, contractors, and assignees (collectively "BioMarin") to use and disclose my protected health information (PHI), including medical records, genetic information, and financial and insurance coverage information, in order to:

- enroll me in, and contact me about, BioMarin RareConnections™
- provide case management, including supporting my treatment, such as through telephone or electronic communications to assist with adherence to my medication regimen
- work with third parties to provide testing for screening, diagnostic, and monitoring purposes, as well as related services (e.g., genetic test interpretation)

In addition, **by checking the boxes below**, I hereby authorize BioMarin to use and disclose my PHI in order to:

☐ provide me education and information relating to my treatment (including treatment alternatives), and organize additional services to help support my treatment, e.g., through healthcare and social services providers

☐ provide me information about clinical trials that may be appropriate for my condition and/or diagnosis

☐ conduct market research relating to my treatment, such as through patient surveys

I understand that I do not have to sign this Authorization. If I do not sign, however, I will not be eligible to receive services from BioMarin. I further understand that I do not have to check any of the boxes above. If I choose not to check the boxes, I understand that BioMarin will not be able to provide me with the related services. However, even if I do not check any of the boxes, I am still eligible to receive BioMarin RareConnections services, as long as I sign this form.

I also understand that I may cancel this Authorization at any time by faxing a signed letter to BioMarin at the number listed below. Canceling this Authorization will mean that I can no longer receive services from BioMarin and will stop BioMarin from making further use and disclosures of my PHI in order to provide services. However, even after I cancel this Authorization, BioMarin may still use and disclose my PHI as required by law or as necessary to ensure the quality and integrity of the services provided by BioMarin RareConnections.

This Authorization will expire 10 years after the date that I sign this form. I understand that I will receive a copy of this signed Authorization upon request from BioMarin Pharmaceutical Inc.

BioMarin Authorization

I have read and understand the terms of this Authorization. By signing this form, I knowingly and voluntarily authorize the use and disclosure of my PHI (including genetic information) as described earlier on this form. I understand that BioMarin does not in any way promise that it can find ways to pay for medically necessary products and services, and I know that I may have to pay for the costs of my care. I agree that a copy of this form may be treated as a signed original.

Patient/Authorized Representative Signature

Date

Print Patient's Name

Patient's Date of Birth

Print Authorized Representative's Name (if applicable)

Relationship to Patient

Patient/Authorized Representative Address

City, State, Zip Code

Patient/Authorized Representative Telephone Number

Best Time/Way to Contact Patient

Patient/Authorized Representative Email Address

Please fax completed form to **1.888.863.3361** or email to support@biomarin-rareconnections.com. Provide a copy of this form to the patient and place the original in the patient's medical record.

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Request to Provide Access to Laboratory Reports to BioMarin

I have agreed to enroll in the BioMarin RareConnections™ program and to allow BioMarin Pharmaceutical Inc. and its agents, contractors, and assignees (collectively "BioMarin") to use and disclose my protected health information (PHI) to provide certain services to me. I hereby exercise my right to access my laboratory test results by requesting that any laboratory that holds results of laboratory tests (including genetic tests) it has conducted on me provide a copy of my laboratory test report to BioMarin upon BioMarin's request. I understand that BioMarin will use and disclose any PHI contained in the laboratory test report only as I have previously authorized.

_____

Patient/Authorized Representative Signature

_____

Date

_____

Print Patient's Name

_____

Print Authorized Representative's Name (if applicable)

_____

Relationship to Patient

Please fax completed form to **1.888.863.3361** or email to support@biomarin-rareconnections.com. Provide a copy of this form to the patient and place the original in the patient's medical record.

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