R-PHARM US
ACCESS + SUPPORT™
Committed to patients. Committed to care.

2730 S. Edmonds Lane
Suite 300
Lewisville, TX 75067

Patient authorization form

Patient information

Name_____ Date of birth___/___/___ Social Security number*_____ Gender: ❑ Female ❑ Male
First Middle initial Last *Providing Social Security number is optional.

Address_____ City_____ State_____ Zip_____

Home phone [_____] _____ Cell phone [_____] _____ Patient e-mail address_____

I am requesting assistance with: ❑ IXEMPRA® (ixabepilone)

Patient authorization and agreement

Please read and sign the patient authorization and agreement.

By signing this authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form and any prescription ("Protected Health Information"), to Sonexus Health—and its representatives, agents, and contractors for the following purposes: **(1)** to establish my eligibility for benefits; **(2)** to communicate with my healthcare providers and me about my medical care; **(3)** to facilitate the provision of products, supplies, or services by a third party including, but not limited to specialty pharmacies; **(4)** to register me in any applicable product registration program required for my treatment; and **(5)** to contact me with educational or treatment support materials and requests for participation in patient programs related to treatment.

I understand that I may refuse to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization. I understand that I am entitled to a copy of this authorization. I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to R-Pharm US Access and Support c/o Sonexus Health, 2730 South Edmonds Lane, Ste. 300, Lewisville, TX 75067, but that this cancellation will not apply to any information already used or disclosed through this authorization.

SIGNATURE **I have read this authorization and agree to its terms:**

_____ _____
Print name of patient or personal representative Description of personal representative's authority

_____
Signature of patient or personal representative Date

For reimbursement assistance, call the Support Center at **1-855-991-7277**,
8 AM to 8 PM ET, Monday-Friday, fax **1-877-541-7813**, or visit **rpharm-us.enrollsource.com**.