OPTUM® | Frontier Therapies

Patient consent form

Return completed form to Frontier Therapies directly by:
Fax: 1-866-991-9929
Mail: 6425 Santa Margarita Street, #110, Las Vegas, NV 89118
Email directly to your care ambassador
OR
Print and fax your completed form to BioMarin RareConnections™ at 1-833-869-0323, or take a photo and text it to 1-866-869-0066. Additionally completed forms can be emailed to BioMarin RareConnections™ at support@biomarin-rareconnections.com.

Patient authorization to use and disclose protected health information

1. Authorization for uses and disclosures. I hereby authorize and direct (1) all of the health care providers and pharmacies involved in my care and treatment, as well as their employees, office staff and agents including affiliated health care practitioners (collectively "Providers"), and (2) health care plans and insurers (collectively "Insurers") to use and disclose my protected health information ("Information"), as described below, to BioMarin Pharmaceutical Inc. and its representatives and contractors (collectively, "BioMarin"). I also expressly authorize all the uses and disclosures described herein where the Information is provided to BioMarin by me.

2. Description of information. I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information and records, including information about my health condition and treatment, and financial information (including information about my insurance) as well as other personal information collected by Providers and/or Insurers about me or otherwise provided by me to BioMarin.

I understand that my pharmacy, health insurers and third-party vendors may receive remuneration (payment) from BioMarin. in exchange for disclosing my personal information to the BioMarin. and/or for providing me with support services for the purposes described above.

3. Purposes. I authorize and direct Providers and/or Insurers to use and disclose my Information to BioMarin for the following purposes:

a. Operating and administrating medication access programs, including, but not limited to BioMarin RareConnections;
b. coordination of prescription fulfillment through pharmacies;
c. medication adherence and compliance programs;
d. soliciting my participation in patient outreach and advocacy programs; and/or
e. other purposes related to patient care and access or similar activities.

4. Expiration. I understand that this authorization will expire sixty (60) months from the date of my signature as noted below unless I revoke it in writing, request a different date below, or am a resident of a state that requires a shorter timeframe.
If I wish for this authorization to expire on a different date, I will note it here: _____
If you are a resident of Maine, Maryland, Minnesota or Montana, the expiration date cannot exceed the following: ME- 30 months; MD-12 months; MN-12months; MT-30 months.

5. Revocation. I understand that I have the right to revoke this authorization by requesting this in writing to Optum® Frontier Therapies at 6425 Santa Margarita Street, #110, Las Vegas, NV 89118. However, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this authorization.

6. Treatment not conditioned; signing is voluntary. I understand that Providers, Insurers, and/or BioMarin will not condition my treatment on signing this authorization. I can choose not to sign this authorization. However, if I choose not to sign, BioMarin will not be able to help me with the various access programs and other activities outlined above in section 3.

7. Potential for redisclosure. I understand that Information disclosed pursuant to this authorization may be redisclosed by BioMarin and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA), a federal privacy law.

*Indicates a required field

Patient name (please print):*

Patient / Parent or Guardian:*

☐ Patient ☐ Parent or Guardian

Patient/Parent or Guardian name (if patient is under 18 years of age) (please print):*

Description of relationship to patient:

Additional Parent or Guardian name (if patient is under 18 years of age) (please print):

Description of relationship to patient:

☐ By checking this box, I authorize the use of my Information for BioMarin marketing activities and consent to receive marketing and promotional communications from BioMarin, including information about opportunities to participate in market research.

By signing below, I am consenting to the use of my protected health information as described above.

Patient/Parent/Guardian/Personal representative signature:*

Additional Parent/Guardian/Personal representative signature: