

In order to receive KALBITOR Access<sup>®</sup> services, you must complete this KALBITOR Access Patient Authorization. Please note that you do not need to complete this authorization to start KALBITOR<sup>®</sup> (ecallantide). You may:

- fax this completed form to KALBITOR Access at 1-888-806-4829, or
- call KALBITOR Access at 1-888-4KALBITOR (1-888-452-5248) for instructions on how to sign this form electronically

### Authorization to Share Protected Health Information

Some Information collected by KALBITOR Access, such as my name and address, personally identifiable insurance, prescription, and medical information, is “protected health information.” The collection, use and disclosure of such protected health information are protected under law. In order for the KALBITOR Access program to provide me with the services described in the KALBITOR Access services overview, the staff may need to review, use, and share my protected health information with certain authorized individuals.

By signing the KALBITOR Access Patient Authorization, I agree to the collection, use, and disclosure of my protected health information to coordinate the delivery of my care. I am giving the KALBITOR Access program the right to request, receive, collect, use, and disclose information from my doctor, healthcare provider, health plan, health insurer, pharmacist, or others necessary to assist with:

- (1) establishing insurance coverage for KALBITOR;
- (2) helping to arrange financial assistance to help pay for my KALBITOR treatment by contacting my insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs on my behalf in order to determine if I am eligible for other health insurance coverage funds;
- (3) coordinating delivery and administration of KALBITOR to my designated treatment site(s);
- (4) providing educational and support services and materials related to KALBITOR treatment;
- (5) collecting information related to KALBITOR treatment to assist in the coordination of care; and/or
- (6) disclosing any information obtained from the sources listed above to third parties if required by law.

I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.

I understand that my healthcare professionals, health plans, and health insurers may not condition treatment, payment, enrollment in a health plan, or eligibility of benefits on whether or not I sign this authorization. I acknowledge, however, that Dyax Corp., the manufacturer providing KALBITOR, may not be able to provide me with full KALBITOR Access services described above unless the KALBITOR Access program staff is able to receive from me, my healthcare professionals, health plans, and health insurers, the protected health information described in this authorization.

I understand that I may inspect or copy the protected health information to be used or disclosed. I understand that I will receive a copy of this signed authorization upon request.

To find out how to cancel your authorization, contact KALBITOR Access at 1-888-4KALBITOR (1-888-452-5248). My cancellation will not be effective to the extent that authorized individuals listed above have already relied on my authorization, and/or information has been disclosed to a third party. Unless cancelled sooner, this Authorization will expire 5 years from the day it is signed.

### I have read and understand the Authorization to Share Protected Health Information.

X Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

X Print Patient Name: \_\_\_\_\_

X Contact Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

X Patient Date of Birth: \_\_\_\_\\_\_\_\_\\_\_\_\_\_

X Patient Email Address: \_\_\_\_\_

X Patient Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Call KALBITOR Access at the number below with questions.

### General Authorization (Optional)

I authorize Dyax, the manufacturer providing KALBITOR, and companies working with Dyax to provide me with information related to KALBITOR and HAE or to ask me about my experiences with, or thoughts about, products, services, and programs that Dyax offers or sponsors. I understand and agree that any information I provide may be used by Dyax to help develop new products, services, and programs. I understand and agree that Dyax and companies working with Dyax may contact me by mail, email, and/or telephone.

This authorization is optional and you do not have to sign this section to receive the KALBITOR Access program services as described above.

### I have read and understand the “General Authorization” and hereby agree to the terms set forth in the Authorization.

X Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

X Print Patient Name: \_\_\_\_\_