PATIENT AUTHORIZATION FORM

Patient's Name (Last, First) _____ **DOB** _____ /_____ / _____

Please read through the following notices carefully. Signing this form will allow Biocodex, Inc. to provide you or your loved one with support and resources that may include but are not limited to:

- **Education about your DIACOMIT®(stiripentol) and what to expect on treatment**
- **Financial assistance for eligible patients and reimbursement information**
- **Helpful resources to help you stay on track**

Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize my healthcare providers, health insurance, and pharmacy provider ("Health Care Providers and Insurers") to use and disclose my personal health information, including information relating to my medical condition, treatment, care management, and health insurance (my "Information") related to my use or potential use of DIACOMIT (stiripentol) to BIOCODEX, Inc. ("BIOCODEX"), and each of their respective affiliates, representatives, contractors, vendors, and other agents (collectively, "RECIPIENTS") and authorize the Recipients to use such information to: (1) contact my healthcare provider, insurance company, or other third-party payers about my Information and to use and disclose this Information, and authorize those parties to disclose (ie, release) all such Information to the Recipients to assist in obtaining coverage for DIACOMIT (stiripentol); (2) provide me with support services for DIACOMIT (stiripentol); (3) contact me and leave messages about DIACOMIT (stiripentol); (4) provide me with information or materials related to DIACOMIT (stiripentol) or my relevant medical conditions; and (5) contact me about DIACOMIT (stiripentol), which may include patient services such as education, training, nurse, and pharmacy support.

I understand that once my Information has been disclosed to the Recipients, state and federal privacy laws may no longer protect the Information and that it may be subject to further disclosure by the Recipients. I understand that Biocodex will protect My Information by sharing it only for the purposes described above or as permitted by law. I understand that the companies working with Biocodex, including my pharmacy, may receive payment for the use and disclosure of my PHI. I further understand that I may refuse to sign this authorization and that my refusal to sign this authorization will have no impact on my eligibility to receive health plan benefits or treatments from my healthcare providers, but I will not have access to support services from the Recipients. I understand that I have the right to revoke this authorization at any time in the future, except to the extent that actions have been taken in reliance on the authorization, by submitting a written notice to Biocodex by mail to Biocodex, Inc., 550 Hills Drive, Suite 200B Bedminster, NJ 07921 or via fax to 833-871-4137. I understand that Biocodex must be notified to fully revoke my authorization, and after I have revoked my authorization, the notified Recipient will stop using the personal and medical information already obtained for the purposes of any support services described above. I am entitled to a copy of this authorization, which expires 10 years from the date it is signed by me (unless earlier termination is required by applicable state law).

Biocodex By Your Side Patient Support Services

By signing this Authorization, I understand I am giving Biocodex Pharmaceuticals, its affiliates, and business partners permission to use and disclose my information to provide product support and resources, including enrollment in the Patient Support Program. I also authorize Biocodex to contact me by mail, email, telephone call, or text about disease and product information, disease or product-related events, support services, market research, and to share other promotional information. I understand I can opt out by submitting a written notice to Biocodex by mail to Biocodex, Inc., 550 Hills Drive, Suite 200B Bedminster, NJ 07921 or via fax to 833-871-4137.

I have read and agree to the Authorization to Share Health Information and Authorization for Patient Support Services.

Patient Signature _____ Date _____ / _____ /_____

Legal Guardian/Parent Signature (if applicable) _____ Date _____ / _____ /_____

Legal Guardian/Parent Printed Name (if applicable) _____

ONCE THE PATIENT HAS READ AND SIGNED THIS AUTHORIZATION FORM, PLEASE FAX IT TO 1-833-871-4137.

Please see full prescribing information before prescribing DIACOMIT® available at: https://www.diacomit.com/PI.