Patient Authorization for Use and Disclosure of Health Information

Send this completed form to ArdelyxAssist™ either by faxing to 1-877-594-4906 or emailing assist@ardelyxassist.com

Patient First Name	Patient Last Name	Patient Date of Birth
Patient Address		
Patient Phone	**Patient Email**	**Patient Gender**

ArdelyxAssist is a patient support program sponsored by Ardelyx, Inc., the manufacturer of XPHOZAH® (tenapanor), that provides patient support services in order to help eligible patients access XPHOZAH and obtain information related to patients' prescriptions for XPHOZAH. Through ArdelyxAssist, we also provide support with certain ongoing administrative tasks, as described below.

I give permission for my healthcare providers, pharmacies, service providers, and their contractors ("**Healthcare Providers**"), and health insurers and their contractors ("**Insurers**"), to disclose my health information, including information about my health insurance benefits, prescriptions, and my medical condition and history ("**Personal Health Information**") to Ardelyx, Inc., its affiliates, vendors, business partners, and agents (collectively "**Ardelyx**") for the following purposes:

- Facilitate my access to XPHOZAH by helping to verify insurance coverage, support reimbursement-related activities, and coordinate my receipt of and payment for XPHOZAH
- Provide access to copay assistance and free product, if eligible
- Provide me with prescription renewal support
- Transmit my prescription electronically, by facsimile, verbally or by mail to a pharmacy designated by the program for the dispensing of the medication called for herein

I also give my permission to Ardelyx, Inc., its affiliates, vendors, business partners, and agents (collectively "**Ardelyx**") to:

- Contact me for feedback about Ardelyx products and disease states related to my condition or treatment. I understand that my participation in any such programs or surveys is optional, and that I may elect not to participate in any such programs or surveys
- Provide me with information about Ardelyx products, disease education and awareness and management programs, and promotional materials related to my condition or treatment , as described in Ardelyx's privacy policy, https://ardelyx.com/privacy-policy/
- By checking here, I elect to opt-out of providing feedback and receiving information about Ardelyx's products, etc. ☐

I understand that once my Personal Health Information is disclosed, it may no longer be protected by federal or state privacy laws. ArdelyxAssist may use my information to manage the ArdelyxAssist program, which may include conducting quality assurance, surveys, and other internal business activities in connection with the support program and related service offerings. I understand that I may refuse to sign this authorization. I also may revoke (cancel) or get a copy of this authorization at any time by calling 1-877-527-3927, emailing assist@ardelyxassist.com, or by writing to ArdelyxAssist, Care of Occam Health Services, 45610 Woodland Road, Ste 320, Sterling, VA 20166. I also understand that if a Healthcare Provider or Insurer is disclosing my Personal Health Information to Ardelyx on an authorized, ongoing basis, my cancellation with Ardelyx will be effective with respect to any such Healthcare Provider or Insurer as soon as they receive notice of my cancellation.

If I am seeking or eligible for financial assistance into the Patient Assistance Program, I am providing written instructions to the Program under the Fair Credit Reporting Act that Ardelyx has my permission to obtain credit reports about me from credit reporting agencies to estimate my income for determination of my eligibility for financial assistance through the program. Regardless of whether a credit report is obtained, Ardelyx has the right to require written proof of income (ie, Form 1040, W-2, or other documents) in connection with a financial eligibility determination both prior to acceptance into the Ardelyx Patient Assistance Program or during my enrollment in the program. I understand that my credit score will not be impacted and I may opt-out at any time by contacting the ArdelyxAssist program.

My refusal or future revocation will not affect my medical treatment or insurance benefits; however, if I revoke this authorization, I may no longer be able to participate in the ArdelyxAssist support program and related programs. If I revoke this authorization, Ardelyx will stop using or sharing my Personal Health Information (except as necessary to end my participation in the program), but my revocation will not affect uses and disclosures of Personal Health Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for 5 years after the date of my signature unless I revoke it earlier or where required by law. I also understand that the XPHOZAH support program may change or end at any time without prior notification.

I have the right to withdraw my consent at any time by emailing assist@ardelyxassist.com.

Telephone Consumer Protection Act (TCPA) Consent

I agree to be contacted by Ardelyx by mail, email, telephone calls, and text messages at the numbers and address(es) provided on this form for all purposes described in this Patient Authorization. I also agree to be contacted by Ardelyx and others on its behalf by telephone calls and text messages made by or using an automatic telephone dialing system or pre-recorded voice, at the number(s) provided on this form, including but not limited to, sending me materials and asking for my participation in surveys.

I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify Ardelyx promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that Ardelyx does not permit my Personal Health Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Health Information transmitted by email and cell phone cannot be secured against unauthorized access.

By signing below, I certify that I am the patient or their legal representative and that I have read and agree to the above patient authorization.

_____ _____

Patient or Authorized Patient Representative Signature **Date**

_____

Patient or Authorized Patient Representative Name (Please Print)

If authorized patient representative, please print name/relationship to patient. Only authorized representatives with legal authority for healthcare decisions may apply on the patient's behalf.