

Please read the following carefully, then sign and date where indicated below.

I hereby authorize my healthcare providers, pharmacies and health insurers, and their service providers ("Providers") to use, release, or disclose information relating to my insurance benefits, medical condition, treatment, and prescription details ("Personal Information") to LEO Pharma Inc., its affiliates, business partners, agents, and service providers, including patient support program service providers (collectively, "LEO Pharma"), in order to receive or be eligible to receive the following LEO Pharma services (the "Services"):

- Assistance coordinating insurance coverage for, access to, or receipt of my prescription medication from LEO Pharma or with training on proper and safe use of prescription medication from LEO Pharma
• Communications through phone, text, or email about possible access, savings and support services, including, for example, LEO Pharma patient support programs, and, if I am enrolled, assistance administering my participation in those programs
• Communications through phone, text, or email about my prescription medication from LEO Pharma and treatment, including, for example, reminders, health and lifestyle tips, product, and program-related information. Communications may be customized based on Personal Information obtained from my Providers
• Participation in quality assurance activities such as surveys and feedback related to the Services or my treatment

In delivering the Services, LEO Pharma may release or disclose my Personal Information (including the personal health information set forth therein) to my Providers and certain financial assistance programs that may assist with my prescription medication payments. I understand and acknowledge LEO Pharma and Providers may combine my records and information with information and data collected from other sources and use that aggregated information to administer the Services listed above. I understand and acknowledge LEO Pharma may be required to share my records and information with law enforcement authorities or other government officials, or when required by law, statute, regulation, or a judicial or administrative order. I understand and acknowledge that my Providers may receive payment from LEO Pharma for providing certain aspects of the Services, such as medication or refill reminders, based on my enrollment or participation.

I understand and acknowledge that my medical records may contain information about psychiatric disorders, human immunodeficiency virus (HIV) test results, acquired immunodeficiency syndrome (AIDS), AIDS-related conditions, alcohol dependence, drug dependence or abuse, and/or a substance use disorder. Once I authorize the release of my records and information, I understand and acknowledge it may be re-disclosed by the recipient and it may no longer be protected by federal or state health privacy laws or other applicable data protection laws or regulations.

I understand that this Authorization is voluntary and that I do not have to sign it in order to get treatment or payment of, eligibility in or enrollment benefits from my insurers.

I understand that I can revoke this Authorization at any time by calling 1-844-692-3279 or by emailing info@Adbry-advocate.com or writing to:

Adbry® Advocate™ Program
PO Box 1587
Jeffersonville, IN 47131

OR
LEO Pharma Support Services
7 Giralda Farms
Madison, NJ 07940

This Authorization will expire 5 years after I sign it, or earlier if required by law, unless I revoke it sooner. If the Authorization expires or is revoked, I understand and acknowledge that I may no longer qualify for Services from LEO Pharma, but it will not impact my Providers' treatment or my insurance benefits. I also understand and acknowledge that if a Provider is disclosing my records and personal health information to LEO Pharma on an authorized, ongoing basis, my revocation of this Authorization will be effective with respect to that Provider as soon as that Provider receives notice of my revocation and such revocation will not affect prior uses or disclosures of my records and personal health information. I understand that I will be able to keep a copy of this Authorization and may, at any time, request a copy of this Authorization. My information may be de-identified and aggregated by LEO Pharma. I am able to learn more about privacy rights within the LEO Pharma Inc. privacy policy, located at https://www.leo-pharma.us/Home/Privacy.aspx. I understand that my information will be used by LEO Pharma in accordance with the LEO Pharma Inc. privacy policy, located at https://www.leo-pharma.us/Home/Privacy.aspx.

I have read and agree to this Patient Authorization.

Patient Name (Print) _____

Patient DOB (MM/DD/YYYY) _____

Legal Rep Name (Print) _____

PATIENT or LEGAL REPRESENTATIVE SIGNATURE

Today's Date _____

SIGN HERE