AMRYT Assist

MYCAPSSA® (octreotide) capsules
Patient Support Services

Enrollment Form

Phone: 1-833-346-2277 • Fax: 1-833-746-2277

Mycapssa® (octreotide) capsules 20mg

Instructions for Patients

Please read this page carefully and if you agree, sign and date where indicated.
After you have done so, please make a copy for your records.

1. Please read the information on side 2 of this form.
2. Sign the Consent to Enroll in Amryt Assist on side 2.
3. Sign the Authorization to Use Health Information as Part of Amryt Assist at the bottom of side 2.
4. Once signed, please fax, email or put in US mail. Your healthcare provider can fax the signed document for you.
5. You will receive a call from a Mycapssa Amryt Assist Case Manager within 1 to 2 business days. The phone call may come from an unfamiliar number.

About Amryt Assist

Amryt Assist is an optional service that provides comprehensive and personalized support for you throughout your journey with MYCAPSSA® (octreotide) delayed-release oral capsules. After signing on the next page, you'll be assigned a dedicated Case Manager and Amryt Clinical Educator who will help support you with:

1. Comprehensive assistance with understanding and navigating insurance for both you and your doctor
2. Specialty Pharmacy assistance to help make the process of ordering and receiving MYCAPSSA as easy as possible
3. Educational resources for patients and caregivers*
4. Appointment reminders, helpful tips for dosing and titration, and additional support along the way*

For more information or if you have questions, please call 1-833-346-2277.

*Contact your healthcare provider with any questions about your individual health.

For questions, call 1-833-346-2277.

AMRYT PHARMA

Consent to Enroll in Amryt Assist

I am enrolling in the Amryt Assist program ("Program") and authorize Amryt and its third-party business partners, vendors, and agents ("Partners") to provide me with services under the Program, as described above and as may be added in the future. Such services include medication and adherence communications and support, medication dispensing coordination, reimbursement and financial assistance services, disease and medication education, and support services for family members and caregivers ("Services"). The MYCAPSSA copay program is available only to patients who reside in the United States or Puerto Rico, and who have commercial prescription insurance coverage or Federal Employees Health Benefits (FEHB) Program coverage for MYCAPSSA. The copay program is not available to patients who are covered by Medicare, Medicaid, TRICARE, or any other federal or state government plans, or who are uninsured.

I agree that, in connection with the Services, Amryt and its Partners may use information about me and share this information with my healthcare providers, specialty pharmacies, insurers, and caregivers listed below on this form. I also authorize Amryt and its Partners to contact me by mail, telephone, email, or text* with disease state information and information about Amryt products, promotions, services, and research studies, and to ask my opinion about such information and topics, including through market research and disease-related surveys. I further authorize Amryt and its Partners to de-identify my health information and use it for research, education, and commercial purposes. I understand that Amryt and its Partners may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services and to send the communications listed above.

I understand that I do not have to enroll in the Program and that I can still receive MYCAPSSA, as prescribed by my physician. I may opt out of individual Services offered by the Program or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1-833-346-2277 or by sending a letter to Amryt Pharmaceuticals, Attn: Amryt Assist, 160 Federal Street, 21st floor, Boston, MA 02110.

*Amryt and its Partners will only text with your permission; some fees may apply.

This authorization will expire 10 years after the date that it is signed unless a shorter period is mandated by state law, or I revoke my authorization before then.

By signing below, I certify that I have read all information on page 2, I understand the Consent to Enroll in the Amryt Assist program on page 2, and I consent to my enrollment in the Program.

I understand that I, as the patient or caregiver, have a right to receive a copy of this signed form over the time that it is valid.

X _____ / / _____

Signature of Patient or Patient Representative | Date

Printed Name | Relationship to Patient (if signed by a Patient Representative)

Authorization to Use and Share Health Information as Part of Amryt Assist

Please read this page carefully and if you agree, sign and date below. After you have done so, please make a copy for your records.

I am enrolling in the Amryt Assist program (the "Program") provided by Amryt and its third-party business partners, vendors, and other agents ("Partners"). I authorize my healthcare providers and their staff, my health insurer, and the pharmacy that dispenses my Amryt medication to use and disclose to Amryt and its Partners health information about me, including information related to my medical condition and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the Program (my "Information") for the purposes of enrolling me in and providing services under the Program, and for the other purposes described in the Consent to Enroll in the Amryt Assist program section on page 2.

Once my Information has been disclosed to a third party, I understand that federal privacy laws may no longer protect it. However, I understand that Amryt and its Partners agree to use and disclose my Information only as allowed by me in the Consent to Enroll in the Amryt Assist program section on page 2.

I understand that the pharmacy that is dispensing my Amryt medication may receive payment from Amryt for the expense of putting together and sending data about its dispensing of MYCAPSSA to me. I understand that I do not have to sign this authorization. A decision by me not to sign this authorization will not affect my ability to obtain medical care, insurance coverage, access to health benefits, or Amryt medicines. However, if I do not sign this authorization, I understand that I will not be able to participate in the Program.

I understand that this authorization shall remain in effect throughout my participation in the Program unless and until I take it back. I may change my mind and take back this authorization at any time by writing to Amryt Pharmaceuticals, Attn: Amryt Assist, 160 Federal Street, 21st floor, Boston, MA 02110 or by calling 1-833-346-2277. I understand that taking back this authorization will end my participation in the Program, and will not affect any use or disclosure of the Information made before my request is received and processed.

By signing below, I certify that I have read all information above, I understand the Authorization to Use and Share Health Information, and I authorize the use and disclosure of my protected health information as outlined above.

X _____ / / _____

Signature of Patient or Patient Representative | Date

Printed Name | Relationship to Patient (if signed by a Patient Representative)