ACTELION

zavesca® miglustat

AUTHORIZATION TO SHARE HEALTH INFORMATION

ZAVESCA CARES™ PROGRAM

I would like to participate in the Zavesca Cares program. Zavesca Cares is a patient education, support, and service program sponsored by the manufacturer of Zavesca® (miglustat), Actelion Pharmaceuticals US, Inc. Zavesca Cares offers educational, patient support, and/or marketing materials and services related to my Zavesca therapy including information about Zavesca, my condition, diet management, and other general patient support, education, and marketing programs that may be of interest to me.

By signing below, I authorize Actelion Pharmaceuticals US, Inc, its affiliates and agents, (collectively "Actelion"), and any pharmacy, health plan, and healthcare provider to use and/or disclose my protected health information (PHI) to operate the Zavesca Cares program including patient education programs, manufacturer related services, and for marketing purposes. This means I permit my specialty pharmacy to share my PHI with Actelion. Generally speaking, my PHI is health information in a format that identifies me or could be used to identify me.

I permit Actelion to contact me by phone, mail, or other similar means. This authorization also permits Actelion to contact the primary caregiver (e.g. friend, family member) that I have listed below on my behalf. I understand that completing this Authorization does not ensure receipt or qualification of therapy or provision of financial or product based assistance. I understand that my ability to obtain medical treatment and/or health plan payment for my medical care is not conditioned in any way upon my signing this Authorization.

I may revoke this Authorization at any time by submitting a request in writing to Zavesca Cares; Actelion Pharmaceuticals US, Inc.; 5000 Shoreline Court, Suite 200; South San Francisco, CA 94080. I understand that the revocation will not apply to information already released pursuant to this Authorization and that once PHI is disclosed based on this Authorization, the information may be redisclosed and may no longer be protected by federal privacy laws.

I acknowledge that I have been provided a copy of this Authorization. Unless otherwise revoked, this Authorization will expire at the end of my treatment with Zavesca. I certify that the information I have provided in this document is true, correct and complete.

I know that I may refuse to sign this form. I understand that if I do not sign this form, I may not participate in the Zavesca Cares program.

Patient signature: _____ Date: _____

Patient name: _____ Caregiver name: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Phone number: _____ Mobile number: _____

E-mail address: _____ Caregiver phone: _____

Personal Representative Section: If this form is signed by someone who is not the patient listed at the top of this Authorization, the patient's personal representative should sign their name below and describe their legal authority to act for the participant.

Representative name: _____ Signature: _____

Relationship: _____

Fax the completed form to 866-782-6163, or mail in the prepaid envelope to:
Zavesca Cares, Actelion Pharmaceuticals US, Inc, 5000 Shoreline Court, Suite 200, South San Francisco, CA 94080