IMCIVREE® (setmelanotide) injection | Rhythm InTune Support made personal

# Patient Consent Form Instructions

Phone: 1-855-206-0815
Email: patientsupport@rhythmtx.com

## Enroll in Rhythm InTune

This is the Consent Form used to enroll in Rhythm InTune, a patient support program from Rhythm Pharmaceuticals. Once you're enrolled, you can expect support in 4 areas:

Understanding insurance coverage

Getting started on a Rhythm treatment

Accessing educational resources

Exploring financial support options

## Complete your Consent Form in 3 easy steps

**1. Read** the Consent Form on pages 2 and 3.

**2. Complete, sign, and date** the Consent Form.

**3. Email a photo or scanned copy** of the Consent Form to: **patientsupport@rhythmtx.com**. If you are unable to email your form, call Rhythm InTune for more options.

## Questions?

Talk to your healthcare provider, or call **Rhythm InTune** at **1-855-206-0815**.

**Once you send this form back to us, we can begin assisting you.**

You can choose not to sign this form. Please know that without your signed authorization on the next page, Rhythm cannot perform an insurance benefit investigation or provide other financial assistance options. However, your decision whether or not to enroll in Rhythm InTune does not impact your ability to gain access to IMCIVREE from your healthcare provider or health plan.

IMCIVREE® (setmelanotide) injection | Rhythm InTune Support made personal

# Patient Consent Form

Phone: 1-855-206-0815
Email: patientsupport@rhythmtx.com

## Patient information — Patient or legally authorized representative to complete this page

Patient name (first, middle initial, last): _____

Date of birth (MM/DD/YYYY): _____

Last 4 digits of patient SSN: _____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Gender: ☐ Male ☐ Female ☐ Non-binary

Street: _____ City: _____ State: ____ ZIP: _____

Home phone: _____ Cell phone: _____

Preferred: ☐ Home ☐ Cell

☐ OK to leave a detailed message? ☐ OK to send a text?

Email: _____

Name of person completing form: _____

Relationship to patient: _____ Phone: _____

## Section A — Consent for support services

**Check this box** ☐

I (or my representative) am electing to enroll in Rhythm InTune ("Services") and agree to the use and disclosure of my information in connection with such Services (which may include, but are not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, alternate funding sources, and other related programs) and to communicate educational and/or promotional information to me about IMCIVREE and related Rhythm products and services. I authorize Rhythm, and its representatives, agents, and contractors to provide me with Services. I also authorize Rhythm to contact me or my physician by mail, email, or telephone in connection with the Services. The Company may also share information with my healthcare team for my care.

*For additional information regarding how your information may be used, and how to contact Rhythm with questions or to exercise your rights, please review the Rhythm Privacy Policy (https://www.rhythmtx.com/privacy-policy) or email us at PatientSupport@rhythmtx.com.*

IMCIVREE® (setmelanotide) injection | Rhythm InTune Support made personal

# Patient Consent Form

Phone: 1-855-206-0815
Email: patientsupport@rhythmtx.com

**Patient information** | **Patient or legally authorized representative to complete this page**

Patient name (first, middle initial, last): _____

Date of birth (MM/DD/YYYY): _____

## Section B Patient or legal representative authorization to use and share personal health information

I authorize any health plan, physician, healthcare professional, hospital, clinic, pharmacy provider, or other healthcare provider (collectively, "Providers") to disclose my personal health information, including personal information relating to my medical condition, genetic test results, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Information"), to Rhythm Pharmaceuticals, Inc., its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "Rhythm") in connection with the Company's provision of products, supplies, or services. I authorize the Company to provide this Information to a specialty pharmacy to fulfill the prescription. Further, my Providers and the Company may use and disclose this Information for Rhythm InTune Support Services (if I agree above) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, alternate funding sources, other related programs, and communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance. This Information may also be used for internal purposes by the Company, including data analysis, or to improve, develop, and evaluate products, services, and programs related to my condition. I also authorize the Company to use my Information to provide me with educational and/or promotional information about IMCIVREE and related Rhythm products and services, adherence reminders and support and disease education, and to contact me to conduct market research. I understand that the specialty pharmacy may receive payment for activities described in this authorization. I understand that once disclosed to the Company, my Information disclosed under this Authorization may no longer be protected by federal privacy law, including HIPAA. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by sending written notice of revocation to Rhythm Pharmaceuticals, Inc., 222 Berkeley Street, 12th Floor, Boston, MA 02116. I understand that such revocation will not apply to any Information already used or disclosed through this Authorization. I understand that revoking my Authorization will end my participation in the Rhythm InTune Support Services. This Authorization will remain in effect for five (5) years from today's date, unless a shorter period is provided for by state law. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way my physician, health insurance, and pharmacy providers treat me. I also understand that if I do not sign this Authorization, I will not be able to receive Rhythm InTune Support Services.

**Sign and date here**

| Patient/legal representative signature | Date (MM/DD/YYYY) |
|---|---|
| Patient name | Legal representative name and relationship |