IMCIVREE™ Patient Consent Form

(setmelanotide) injection

Phone: 1-844-YOUR-GPS (1-844-968-7477)

Complete this form and email photo/scanned copy to IMCIVREEGPS@PantherXrare.com.

Patient information — Patient or legally authorized representative to complete

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 — Authorization to share personal health information

Patient or legal representative authorization to share personal health information

I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care 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. 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 understand that the specialty pharmacy may receive payment for the expense of assembling and sending data about me to the Company.

Further, the Company may use and disclose this Information for IMCIVREE GPS Support Services (if I agree below) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance.

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 IMCIVREE GPS 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 IMCIVREE GPS Support Services.

IMCIVREE GPS (Guidance · Partnership · Support) Support Services program enrollment

☐ I am electing to enroll in the IMCIVREE GPS Support Services ("Service") and direct all disclosures of my Information in connection with such Service (which may include, but are not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, and other related programs). I authorize Rhythm and its representatives, agents, and contractors to provide me with Service. I also authorize Rhythm to contact me or my physician by mail, email, or telephone in connection with the Service. The Company may also share information with my healthcare team for my care.

Sign and date here

_____ Patient/legal representative signature

_____ Date (MM/DD/YYYY)

_____ Patient name

_____ Legal representative name and relationship

Section B — Consent for educational information

☐ By checking this box, I (or my representative) also authorize Rhythm and certain authorized parties to send me educational communications such as mailings, emails, newsletters about the product or IMCIVREE GPS Support Services, or occasional communication for market research purposes. I understand that I may opt out of these communications at any time via the link/contact information available in all communications.