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

Patient Consent Form

Phone: 1-855-206-0815
Email: patientsupport@rhythmtx.com
Fax: 1-877-805-0130

Enroll in Rhythm InTune

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

Understanding insurance coverage

Getting started on treatment

Exploring financial support options

Accessing educational resources

Complete your Start 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?

If you have questions about **Rhythm InTune**, you can call us at **1-855-206-0815** or email us at **patientsupport@rhythmtx.com**.

Once you send this signed 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.

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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 Race/Ethnicity: _____

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: _____

Diagnosis: ○ acquired hypothalamic obesity ○ Bardet-Biedl syndrome

○ POMC deficiency ○ PCSK1 deficiency ○ LEPR deficiency

Other (please specify): _____

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.

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

Patient initials: _____ 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 or 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") in connection with the Company's provision of products, supplies, or services. I authorize the company to provide this information, and any specific information related to my prescription that I provide to the Company directly, 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 (Rhythm InTune) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, other related programs, and communication with me or my providers by mail, email, or telephone about my medical condition, treatment, care, 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 understand that Rhythm may de-identify my Information, combine it with other de-identified information about me or others, and use the resulting information for Rhythm's business purposes. 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 for 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 and that revoking my Authorization will end my participation in Rhythm InTune. 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 my refusal 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.

Sign and date here

_____ Patient/legal representative signature

_____ Date (MM/DD/YYYY)

_____ Patient name

_____ Legal representative name and relationship

Optional disclosure authorization:

I also authorize the disclosure of my personal health information to the following designated individual(s)

Name: _____ Relationship to patient: _____