

PATIENT CONSENT

Submission of this form does not guarantee that any services will be provided. Additional information may be needed to assess eligibility for and provide the services, including to access free drug under the A·S·A·P Patient Assistance Program.

PATIENT INFORMATION (COMPLETE IF SENDING PATIENT ENROLLMENT FORM SEPARATELY)

*Required field.

First Name*: _____ Last Name*: _____

Date of Birth*: __/__/____ Gender*: M F O

Address*: _____ City/State*: _____ ZIP Code*: _____

Phone*: Mobile (___) ___-____ Alternate: Home Mobile (___) ___-____

Email Address: _____

Product Prescribed: SKYTROFA® (lonapegsomatropin-tcgd)

Legal Representative Name: _____

(Required if patient is under 18 years of age or if applicable)

Legal Representative Relationship to Patient: _____

(Required if patient is under 18 years of age or if applicable)

Please review the **PATIENT SUPPORT PROGRAM CONSENTS** below before signing.

Consent to Enrollment in Ascendis Signature Access Program (A·S·A·P) (Required). I am enrolling in A·S·A·P (the "Program") and I authorize Ascendis Pharma Endocrinology, Inc. and its subsidiaries, affiliates, vendors, agents, and representatives (collectively, "Ascendis") to provide me services under the Program. Such services include: disease state and product education (including starter kit), medication and adherence communications, insurance coverage and financial assistance support, injection training support, free drug if eligible, coordination of medication delivery, surveys to evaluate, improve, or develop the Program's services and other internal business purposes, and provide me with patient support services under A·S·A·P (the "Services").

Consent to Process My Personal and Sensitive Information (Required). I understand that my/my child's health information, contact information and other identifying information that I, my/my child's healthcare provider or others share with Ascendis is collected for the provision of the Services and for other business purposes of Ascendis, as described in the Ascendis Privacy Policy at <https://ascendispharma.us/privacy-policy/>. I further understand that my consent is required to process my/my child's sensitive information under certain US state privacy laws, and by signing below, I consent to the collection, use, disclosure and processing of my/my child's personal and sensitive information, including my/my child's personal health data, as described in the Ascendis Privacy Policy. I understand that I have the right to withdraw my consent at any time by notifying Ascendis using the contact information above. Depending on where I live, I may have certain rights with respect to the privacy of my/my child's information, including the request to access or delete my/my child's personal information. I am aware that Ascendis may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact Ascendis by phone at 1-844-442-7236, by email at DataPrivacy@ascendispharma.com or may submit a privacy request form, accessible via the Privacy Policy.

OPTIONAL: Text Messaging and Automated Communications Consent: I consent to receive automated and recurring phone calls and text messages from Ascendis, including communications about my prescription, to the phone number provided above. Message and data rates may apply. Message frequency varies. I understand that I am not required to consent as a condition of participating in A·S·A·P, purchasing any goods or services, or receiving any other communications I have selected. At any time, I can reply "STOP" to opt out and "HELP" for help.

Please review the PATIENT PRIVACY AUTHORIZATION below before signing.

By signing below, I authorize each of my/my child's "Healthcare Providers" (eg, physicians, pharmacies, and other healthcare professionals and facilities and their staff) and "Insurers" (eg, my health insurance plan(s)) to share my/my child's protected health information, including information about my/my child's insurance, prescriptions, and medical condition ("My/my child's Information") with Ascendis Pharma Endocrinology, Inc. and its subsidiaries, affiliates, vendors, agents, and representatives (collectively "Ascendis") for the purposes described below. I also authorize my/my child's Healthcare Providers, Insurers, and Ascendis to use My/my child's Information and share it with each other for the purposes described below.

I understand that my/my child's Healthcare Providers, Insurers, and Ascendis will receive, use, and disclose My/my child's Information for the purposes of enrolling me in, and providing services through the Ascendis Signature Access Program (A·S·A·P) (the "Program"), including to: (1) process my/my child's request for enrollment in the Program, determine if I am eligible to participate in the Program, and provide the Services as applicable; (2) verify and assist with my/my child's coverage for the prescribed product indicated above with my/my child's Insurers; (3) evaluate, improve, or develop the Program's services and other internal business purposes; (4) facilitate and manage the Program; and (5) de-identify My/my child's Information and combine it with other de-identified data for purposes of research, education, business analytics, marketing studies, or for other commercial purposes.

Further, to the extent that I provide my/my child's consent for the optional Support Program Consents, I authorize my/my child's Healthcare Providers, Insurers, and Ascendis to use and disclose My/my child's Information for the purposes contemplated therein.

I understand that service providers for the Program may be paid by Ascendis for their services and data. This may include payment for sharing My/my child's Information and other data in connection with the Program, as allowed in this Authorization.

I understand that Ascendis will use reasonable efforts to keep My/my child's Information private, but once My/my child's Information is disclosed as allowed in this Authorization, it may no longer be protected by federal privacy laws. I understand that I am not required to sign this Authorization. My choice about whether to sign will not change how my/my child's Healthcare Providers or Insurers treat me. If I do not sign this Authorization, or cancel or remove my permission later, however, I understand I will not be able to participate in or receive assistance from the Program.

I understand I may request a copy of this Authorization. This Authorization will remain in effect for ten (10) years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in the Program. Information collected before that date may continue to be used for the purposes set forth in this Authorization. I understand that I may cancel the permissions given by this Authorization at any time by informing Ascendis in writing by fax at 1-888-436-0193 or by mail at A·S·A·P, PO Box 1587, Jeffersonville, IN 47131. I can also cancel my permission by informing my/my child's Healthcare Providers and Insurers in writing that I do not want them to share any information with Ascendis. I further understand that if I cancel my permission, it will not affect how Ascendis uses and shares My/my child's Information received by Ascendis prior to my cancellation.

CONFIRMATION OF PATIENT CONSENT AND AUTHORIZATION (ALWAYS COMPLETE IF ENROLLING)

Patient Name: _____

My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the PATIENT SUPPORT PROGRAM CONSENTS including any optional consents identified with a checked box.

By checking this box, I consent to the optional Text Messaging and Automated Communications as described above. I have provided my mobile number in the Patient Information section.

Required – Patient Signature (or Legal Representative[†]):

_____ **Date:** __/__/----

My signature below certifies that I have read, understood, and agree to the release of my protected health information pursuant to the PATIENT PRIVACY AUTHORIZATION.

Required – Patient Signature (or Legal Representative[†]):

_____ **Date:** __/__/----

[†]Only representatives with legal authority for healthcare decisions may certify on a patient's behalf.