**Ascendis Pharma**
**Patient Authorization Form**

I authorize Ascendis Pharma, Inc., its affiliates and the vendors working on Ascendis Pharma, Inc. and its affiliates' behalf (collectively, "Ascendis") and the healthcare providers, pharmacies, insurance companies, third-party payers, or others working on my behalf, to use, share, and store my protected health information (PHI) in order to assess my eligibility for participation in the Ascendis Signature Access Program™ (A·S·A·P), including the audit of my medical records and/or by contacting me directly to confirm my eligibility for participation in A·S·A·P. I understand that Ascendis will use this information in connection with the operation of, and issues related to, A·S·A·P.

I understand that my health information includes information related to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Ascendis so that Ascendis may provide me with various support and information to help me access Ascendis medicine, which may include the following, depending on your program (collectively, "Patient Support Activities"):

- Providing benefits verification and reimbursement support, including:
    - Assistance with identification of my insurer's prior authorization requirements
    - Assistance with identification of my insurer's requirements for appealing a denied claim
- Determining my eligibility for co-pay support or free drug programs
- Providing financial assistance resources and information if I'm eligible
- Sending me a SKYTROFA Auto-Injector and Starter Kit (where appropriate)
- Communicating with my healthcare providers about Ascendis medicine and Patient Support Activities
- Providing me with disease management and other educational materials

Ascendis also may use my health information for quality assurance purposes and to evaluate and improve operations and services.

I understand that I do not have to sign this form, and choosing not to sign will not affect my ability to receive treatment from my healthcare providers or payment from my health insurer. However, if I do not sign this form, A·S·A·P may not be able to provide me with assistance.

I understand the Pharmacy may receive financial remuneration from Ascendis for disclosing PHI to Ascendis and for providing support services to me, including sending communications to me, for purposes of the program as outlined in this authorization.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Ascendis agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law.

I understand that this authorization will remain in effect until I have notified Ascendis that I have completed my growth hormone treatment (unless a shorter time period is required by state law), or unless I notify both my healthcare provider and Ascendis (at fax number 1-888-436-0193) in writing or at PO Box 1587 Jeffersonville, IN 47131 that I revoke this authorization. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

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|---|---|
| Print patient's name | Name of legal representative |
| Relationship to patient | Signature of legal representative |

Date

❑ I also give my permission to receive communications from Ascendis, A·S·A·P, and parties acting on their behalf, including emails, text messages, or calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits information, SKYTROFA Auto-Injector shipment updates, and any other information in support of my access to Ascendis medicine. If I have a caregiver, he or she has also agreed to receive such communications from Ascendis, A·S·A·P, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Ascendis, A·S·A·P, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting A·S·A·P at 1-844-442-7236.

For details about how we collect and use PHI, including applicable US privacy rights and notices for California, Nevada, or Texas residents, please visit https://ascendispharma.us/privacy-policy/.