vyepti connect™

Fax: 866-868-7071 **Phone:** 833-4-VYEPTI **Hours:** 8 AM - 8 PM EST

Website: www.vyepticonnect.com

VYEPTI CONNECT™ Patient Authorization for Use and Disclosure of Protected Health Information

Please Note: This information is for healthcare providers to use to obtain a patient authorization for the VYEPTI CONNECT Support Program. To submit this form, please fax to 866-868-7071.

I authorize my healthcare providers (including pharmacy providers) and health plans to disclose my protected health information, including the information requested on the VYEPTI CONNECT enrollment form, and/or my use or potential use of VYEPTI™ (eptinezumab-jjmr), including my personal contact and other information listed on the VYEPTI CONNECT enrollment form (collectively, my "Information"), to the patient support program, called the VYEPTI CONNECT Support Program (the "Program"), so that the Program may use and disclose the Information in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my benefit and coverage status and my medical care; (3) provide support services, including facilitating the provision of VYEPTI to me, as well as any information or materials related to such services or Lundbeck products, including promotional or educational communications; (4) evaluate the effectiveness of VYEPTI support programs; (5) report safety information, including in communications with the US Food and Drug Administration and other government authorities; (6) contact me regarding this enrollment form or my use or potential use of VYEPTI and provide me with related patient support communications, including through messages left for me that disclose that I take or may take VYEPTI; and (7) allow Lundbeck to analyze the usage patterns and the effectiveness of Lundbeck products, services, and programs and help develop new products, services, and programs, and for other Lundbeck general business and administrative purposes. I understand that entities may receive remuneration in exchange for the provision of my Information as authorized above, and that once my Information has been disclosed to the Program, federal privacy law may no longer restrict its use or disclosure and that my Information may be redisclosed to others. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law. I understand that my refusal to sign this Authorization will not affect my right to treatment or payment benefits for healthcare. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to the VYEPTI CONNECT Support Program/PO Box 29299/Phoenix, AZ 85038-9299, and that such withdrawal will not affect any uses and disclosures of my Information prior to the Program's receipt of the notice. I am entitled to a copy of this signed Authorization, which expires 10 years from the date it is signed by me or such timeframe as allowed by law.

X _____

Patient Signature | Patient Name (print) | Date

Note for California providers: submission of patient-signed Authorization form is required for enrollment in VYEPTI CONNECT.

vyepti™ (eptinezumab-jjmr) 100 mg/mL injection