CAYSTON ACCESS PROGRAM® PATIENT AUTHORIZATION FORM

PHONE: 1-877-7CAYSTON (1-877-722-9786) FAX: 1-877-550-1705

This will help avoid delays at the pharmacy PATIENT NAME: DATE OF BIRTH: / /

1. PATIENT AUTHORIZATION AND CONSENT (READ AND SIGN) — REQUIRED

As further described below, I hereby authorize my providers and health plans to share my personal and medical information as described below with Gilead Sciences, Inc., the manufacturer of CAYSTON® (aztreonam for inhalation solution, 75 mg) ("CAYSTON"), and its contractors for limited purposes, all in accordance with this authorization.

Persons Authorized to Disclose My Information: My healthcare providers, including any pharmacy that fills my prescription for CAYSTON and other drugs or devices, and any Gilead health plans or programs that provide me healthcare benefits.

Information to Be Disclosed: Personal information about me (for example, my name, mailing address, and insurance information) and my medical information (including information about my cystic fibrosis status) (together all such information is called my "health information" in this authorization). I understand that my pharmacy providers may receive remuneration for disclosing my personal and medical information pursuant to this authorization.

Persons to Which My Health Information May Be Disclosed: Gilead, including the third party administrator responsible for the administration of the Cayston Access Program® and the PAP (collectively referred to in this authorization as "Gilead").

Use of Information and Purposes for Which the Disclosures Are To Be Made: 1) establish my eligibility for benefits from my health plan or other programs; 2) provide financial assistance, access reimbursement, and referral support, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of CAYSTON and the Altera® Nebulizer System to me in certain limited situations; 3) to contact me to evaluate therapy, the effectiveness of the program and to conduct market research; 4) for Gilead's internal business purposes, including quality control, and support enhancing surveys; 5) to ensure the accuracy and completeness of my application for assistance; and 6) to send me marketing information, offers, and educational materials related to cystic fibrosis and/or CAYSTON, including the customer relationship marketing program (upon my consent, below).

I understand that once my health information has been disclosed to Gilead, federal privacy laws may no longer restrict its use or disclosure; however, Gilead intends to protect my health information by using and disclosing it for the purposes described above and as required by law. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the support available through this program. I may cancel this authorization at any time by notifying Gilead in writing and submitting it by fax to 1-877-550-1705 or at the Cayston Access Program address below. If I cancel, Gilead will stop using this authorization to access my health information after that cancellation date, but the cancellation will not affect any health information that has already been disclosed in reliance on this authorization before that cancellation date. I authorize the Cayston Access Program to leave a message, including the prescription name if I am unavailable. I am entitled to a copy of this signed authorization, which expires at the earlier of 10 (ten) years or other time period required under the state in which I reside, from the date it is signed by me.

☐ I consent to receive text messages by or on behalf of Gilead at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing any goods or receiving support from Gilead. Message and data rates may apply. (OPTIONAL)

☐ I consent to receive marketing information, offers and educational materials related to cystic fibrosis and/or CAYSTON, including the customer relationship marketing program. I understand that my consent is not required as a condition of purchasing any goods or receiving support from Gilead. (OPTIONAL)

PATIENT NAME (REQUIRED):	**DATE OF BIRTH:** / /
Patient Email:	Cell Phone #: ( ) –
Prescriber Name:	Prescriber Phone #: ( ) –
X **SIGNATURE** (REQUIRED): *(Signature of Patient or Authorized Patient Representative)*	**DATE** (REQUIRED): / /
Authorized Patient Representative Name *(if signing for the patient)*:	
Authorized Patient Representative Relationship to Patient:	

FAX COMPLETED FORM TO CAYSTON ACCESS PROGRAM AT 1-877-550-1705

Cayston Access Program, 6931 Arlington Road, Suite 308, Bethesda, Maryland 20814 (Monday-Friday 8AM - 8PM EST)