Sucraid® (sacrosidase) Oral Solution | Enrollment Form

Need Help?
SucraidASSIST™
Phone: 1-800-705-1962
Fax: 1-866-850-9155
Email: sucraid@qolmed.com

INSTRUCTIONS: Please complete and fax this page to **1-866-850-9155 or email to sucraid@qolmed.com**. Sucraid*ASSIST*™ is provided by QOL Medical, LLC.

HIPAA AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ("AUTHORIZATION")

Program Highlights (or Benefits): The SucraidASSIST™ program is designed to be the primary resource for Sucraid® (sacrosidase) Oral Solution patients, caregivers, and healthcare providers, where ASSIST stands for Access and Support Services in Sucraid® Therapy. QOL Medical offers the SucraidASSIST™ program that provides excellent customer service . QOL Medical is dedicated to improving patient outcomes by assisting customers with understanding their disease and drug.

1. Authorization of Uses and Disclosures. HIPAA Authorization to Use and Disclose Protected Health Information ("Authorization"): 1. Authorization of Uses and Disclosures. I hereby authorize and direct my healthcare providers, health insurance company, Optum Frontier Therapies or any other pharmacy, and their employees and agents as well as affiliated healthcare practitioners (collectively "Provider") to use and disclose my "protected health information" ("Information"), as described below, to (i) QOL Medical, LLC (QOL), the maker of Sucraid®; (ii) QOL or SucraidASSIST™ patient assistance and other personnel; and any agent or representative of any of these parties (collectively "Authorized Parties"). **2. Description of Information.** I understand that my Information includes, but is not limited to, my name, date of birth, gender, and other personal information, contact information, and identifiers (including my address), medical information (including information about my health condition and related medical conditions), symptoms, treatments (including treatment relating to my past, present, and future use of Sucraid® and other healthcare items or services), diet, family medical history, medical records, and financial information (including information about my income, insurance coverage, and payment history), as well as other personal information collected by Provider and/or Authorized Parties about me. **3. Purposes.** I authorize and direct Provider to use and disclose my Information to Authorized Parties for the following purposes: (1) help address issues patient may incur in the prescription process; (2) provide patient and healthcare providers with educational materials; (3) conduct healthcare marketing activities, including those for which Optum Frontier Therapies or QOL receives compensation; (4) conduct clinical assessments regarding symptoms, therapeutic response to Sucraid®, and manner and adherence to treatment regimens; (5) determine potential qualification for patient assistance programs; (6) carry out any other purpose required or permitted by law; and (7) to contact patient for additional information if needed. **4. Potential for Redisclosure.** I understand that once my Information is disclosed under this Authorization, it may be further disclosed and no longer protected by federal confidentiality laws, including HIPAA (a federal privacy law). **5. Treatment Not Conditioned; Signing Is Voluntary.** I understand that treatment by my physician and Provider, payment by my insurance, or enrollment in my health plan is not conditioned upon the signing of this Authorization. However, if I refuse to sign this Authorization, my ability to receive support services related to my use of Sucraid® may be limited. I can choose not to sign this Authorization. **6. Expiration.** I understand that this authorization will remain in effect until the later of ten (10) years from the date of my signature, five (5) years following my discontinuance of purchase of Sucraid®, or as limited by state law unless I revoke it. **7. Revocation.** I understand that I have the right to revoke this Authorization by requesting in writing that this Authorization be revoked by sending written notice to Optum Frontier Therapies at 6325 Santa Margarita St #110, Las Vegas, NV 89118. If I revoke this Authorization, Optum Frontier Therapies will stop using and disclosing my Information for the purposes described above. However, my revocation will not affect any prior use or disclosure of Information made in reliance on this Authorization and my revocation will not affect my treatment by my physician or Optum Frontier Therapies. **8. Questions.** If I have questions about disclosures of my Information, I may contact the Privacy Officer at sucraid@qolmed.com. **9. Copy.** I understand that I will be provided with a copy of this Authorization. I hereby certify that I am over the age of 18 and I have read this document and fully understand the contents. **All fields are required.**

Patient First Name:	Last Name:
Gender: ☐ Male ☐ Female	DOB: / /
Patient Signature (or Caregiver):	Date:
Phone:	Email: Zip Code:
Relationship to Patient:	

Text notifications: By signing below, I expressly authorize Optum Frontier Therapies and its partners to contact me via text with information about my prescription, such as refill reminders. I hereby certify that the number I have provided on this form is mine. I agree to receive text messages that may be sent using an automated telephone dialing system and that there is a risk of interception because text messages are not secure communications. I understand that I am not required to consent to text messages in order to receive services from Optum Frontier Therapies and that I may opt out at any time. Message and data rates may apply.

Mobile Phone:	**Patient Signature (or Caregiver):**