COMPASS PATIENT AUTHORIZATION FORM

Juxtapid (lomitapide) capsules

The purpose of this Authorization form is to permit Compass participants to receive additional information and support ("Patient Support") from Amryt Pharmaceuticals, its affiliates, representatives, agents and contractors ("Amryt"). Please read this form carefully and ask any questions that you may have.

To be read, completed, and signed by patient or patient's personal representative.
PLEASE FAX TO 1-855-898-2498

I. AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

By signing this Authorization, I authorize Accredo Specialty Pharmacy ("Accredo") to disclose my contact information and protected health information (or "PHI") related to JUXTAPID therapy and my disease management, including but not limited to my name, medical and pharmacy records and information relating to payment for my disease treatment, care management and health insurance, as well as all information provided on any JUXTAPID prescription or prescription related to my disease treatment, to Amryt Pharmaceuticals, Inc., and those working on its behalf (collectively, "Amryt") to provide the Patient Support.

II. AUTHORIZATION FOR COMPASS SERVICES AND COMMUNICATIONS

The purpose of this Authorization is to enable me to obtain Patient Support from Amryt, including:

- Investigation of my insurance coverage
- Coordination of benefits and reimbursement support
- Investigation of financial support services and programs, or comparable programs for JUXTAPID that may help me
- Facilitation of claims adjudication and submission of claims to third party payers for payment
- Education and access to patient programs related to JUXTAPID including medication adherence support, nutrition support and access to a registered dietitian, and treatment and medication reminders
- Participation in surveys and quality assessment activities to evaluate the effectiveness of the Patient Support

The Authorization also enables me to receive Marketing communications from Amryt or those acting on its behalf offering programs, services or products of interest to patients taking JUXTAPID.

Amryt is authorized to contact me by mail, e-mail, text, telephone, and/or any alternative communication method that I request in connection with the Patient Support.

Once my PHI has been disclosed to Amryt, I understand that federal privacy laws may no longer protect that PHI. However, Amryt will take reasonable steps to protect my PHI by using and disclosing it only for the purposes described in this Authorization or as otherwise authorized by law.

I understand that I may refuse to sign this Authorization, and that doing so will not affect my ability to receive treatment or benefits to which I am otherwise entitled. I understand that I am entitled to a copy of this Authorization, and that I may revoke this Authorization at any time, by mailing a letter requesting revocation to: Accredo Health Group, Inc. c/o The JUXTAPID Program, 1640 Century Center Parkway Memphis, TN 38134.

I understand that expiration of or revoking this Authorization will end further use and disclosure of my PHI but that it will not affect use or disclosure of PHI that has already been disclosed by Accredo in reliance upon this Authorization.

This Authorization will expire upon my revocation or one year after I receive my last prescription.

AGREED:

Patient Signature: _____ Date: _____

Patient Name (please print): _____

Personal Representative or Guardian Signature (if applicable): _____

Personal Representative or Guardian Name (please print): _____

Relationship to Patient, including the authority for status as Personal Representative: _____

Address of Patient or Personal Representative: _____

Telephone Number: _____ Email Address: _____

Please see Indication and Important Safety Information on pages 3-4 and accompanying full Prescribing Information including Medication Guide and Boxed Warning.