PATIENT CONSENT FORM

To learn more about BioMarin RareConnections™
call **1.833.VOXZOGO** (1.833.869.9646); hours: M–F, 6 AM–5 PM (PT)
or email us at: **support@biomarin-rareconnections.com**

VOXZOGO™
(vosoritide) for injection

To complete and submit this form online, visit VOXZOGO-PCF.com

References to "you," "your," "I," "me," "my," etc. in this form are to the patient, even if an authorized representative is signing this form on the patient's behalf.

FOR BIOMARIN TO ASSIST YOU WITH ITS MEDICINES AND RELATED CARE, YOU WILL NEED TO PROVIDE CONSENT TO BOTH YOUR HEALTHCARE PROVIDER AND BIOMARIN:

- Your healthcare provider needs your written consent to release your protected health information (PHI) to BioMarin
- BioMarin needs your written consent to share your information (including genetic testing information) with other providers to assist you with accessing services that support your treatment
- BioMarin needs your consent to contact you with marketing and other communications about BioMarin's products, services, programs, and other topics of interest for marketing, educational, or other purposes; to assist you getting help through additional services that support your treatment plan; and to allow you to provide feedback to BioMarin through market research
- As described below, your consent is voluntary and is not required for treatment, medications, or other care. Your consent is required for BioMarin to provide the product support services described here

CONSENT TO SHARE HEALTH INFORMATION FOR PATIENT SUPPORT SERVICES

By signing this Patient Consent Form (PCF), I hereby authorize my healthcare providers, health insurance carriers, laboratory providers, and pharmacy providers (Healthcare Entities) to use and disclose my individually identifying health information, including but not limited to health insurance information, medical diagnosis and condition (including but not limited to laboratory test results such as diagnostic results as well as test results related to diagnosis or supportive testing), prescription information, and name, date of birth, sex, address, and telephone number to BioMarin and its agents and representatives, including but not limited to third parties authorized by BioMarin. I further authorize BioMarin to use my individually identifying health information to administer the patient support program through BioMarin RareConnections™ and BioMarin's Clinical Coordinator Program and for the following additional purposes:

- to contact my healthcare provider and collect, enter, and maintain my health information in a database;
- to contact my insurers as needed to verify my insurance coverage, review reimbursement requirements, verify other financial assistance for which I might be eligible, assist with the processing of claims, or otherwise assist in obtaining coverage or financial assistance for my treatment, including but not limited to in relation to post-administration monitoring;
- to determine eligibility for program offerings, including but not limited to financial assistance services; and
- to contact me by mail, email, fax, telephone call, or text message, in electronic format or otherwise, to follow up on any BioMarin RareConnections enrollment requirements, receive education, conduct follow-up on my treatment, discuss the effectiveness of support services, and provide support services, education, and adherence reminders such as to take my BioMarin medication. BioMarin Clinical Coordinators do not work under the direction of your healthcare provider or give medical advice. BioMarin Clinical Coordinators are trained to direct patients to their healthcare provider for treatment-related advice

Once my health information has been disclosed to BioMarin, I understand that federal privacy laws no longer protect the information. However, BioMarin agrees to protect my health information by using and disclosing it only for purposes authorized in this PCF or as required by law or regulations. California residents, to learn more about the information BioMarin may collect about you, how we use that information, and your rights under the California Consumer Privacy Act (CCPA), please review our CCPA Privacy Policy, available at **www.biomarin.com/privacy**. I understand that pharmacy providers may receive remuneration from BioMarin in exchange for the health information and/or for any therapy support services provided.

This PCF expires ten (10) years, or such shorter amount of time required by applicable state law, after the date I sign it as indicated by the date next to my signature, unless otherwise canceled earlier as set forth below. I understand I have a right to receive a copy of this PCF.

CONSENT FOR MARKETING/OTHER COMMUNICATIONS

By signing this Patient Consent Form, I hereby authorize my Healthcare Entities to use and disclose my individually identifying health information to BioMarin for marketing purposes or to otherwise provide me with information about BioMarin products, services, research, clinical trials, and programs or other topics of interest, and to conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that BioMarin and companies working with BioMarin may use my individually identifying information to contact me by mail, email, fax, telephone call, or text message for these purposes. I understand and agree that any information that I provide may be used by BioMarin to help develop new products, services, and programs. I further understand that BioMarin will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission.

VOLUNTARY CONSENT

I understand that I may refuse to sign this PCF. I further understand that my treatment (including with a BioMarin product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this PCF, but if I do not sign it, or if I later cancel it, I will not be able to receive BioMarin's therapy support services.

I understand that I may cancel this PCF at any time by mailing a letter to BioMarin at 2001 Broadway, Suite 300, Oakland, CA 94612 or emailing **support@biomarin-rareconnections.com**. Canceling this PCF will end my consent for my Healthcare Entities to further disclose my health information to BioMarin after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this PCF. Canceling this PCF will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

1 To authorize your consent, please complete all fields below.

Patient's First Name _____ Middle Initial _____ Patient's Last Name _____ Suffix _____ Date of Birth _____ Gender ☐ Male ☐ Female ☐ Other

Patient's/Authorized Representative's Name (if applicable) _____ Relationship to Patient _____

Patient's/Authorized Representative's Address _____ City _____ State _____ ZIP Code _____

Preferred Method of Contact (please specify) ☐ Cell Phone _____ ☐ Home Phone _____

☐ Alternative Phone _____ ☐ Email _____

Preferred Time of Contact ☐ AM ☐ PM Preferred Language ☐ English ☐ Spanish ☐ Other Language (please specify) _____

2 Opt-in for BioMarin access to laboratory reports:

☐ By checking this box, I exercise my right to access my laboratory test results by requesting that any laboratory that holds results of laboratory tests (including genetic tests) it has conducted on me provide a copy of my laboratory test report to BioMarin upon BioMarin's request. I understand that BioMarin will use and disclose any PHI contained in the laboratory test report only in accordance with this PCF.

3 Please read and sign below.

I have read and understand this Patient Consent Form, including but not limited to the Consent to Share Health Information for Patient Support Services and the Consent for Marketing/Other Communications and agree to the terms stated herein. A consent signature is required in order to receive BioMarin services.

Patient's/Authorized Representative's Signature _____ Date _____

Print Authorized Representative's Name (if applicable) _____ Relationship to Patient _____

Print and fax your completed form to 1.833.869.0323, or take a photo and text it to 1.866.869.0066.

To complete and submit this form online, visit VOXZOGO-PCF.com.

Please see full Prescribing Information.

Note for healthcare providers: once your patient has completed this form, provide a copy to them and place the original in the patient's medical record.

BIOMARIN®

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