biolinx℠

Helping Patients and Providers Access Care

Reference Number: _____ *(For BioLinx Usage Only)*

PATIENT AUTHORIZATION FORM

You have expressed an interest in SUPARTZ® (Sodium Hyaluronate) therapy. BioLinx can provide certain services to you and on your behalf during the search for SUPARTZ therapy reimbursement, and during your therapy. BioLinx is an agent of Bioventus.

In order to provide these Services, BioLinx will need to use your health information (called "Protected Health Information" or "PHI"), and to share it with your health plan and the pharmacy that will receive your doctor's prescription. This authorization will allow your healthcare providers, health plans, and health insurers that maintain PHI about you to disclose your PHI to BioLinx so that the Support Center may provide these Services to you, or on your behalf.

AUTHORIZATION AND SIGNATURE:

By signing this Authorization, I authorize my health plans, physicians, health care professional, hospital, clinic, pharmacy or other health care provider to disclose my personal health information, including but not limited to, information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to Bioventus, its affiliates and their representatives, agents and contractors for the following purposes, including but not limited to investigating insurance coverage, fulfilling and coordinating delivery, assisting with product training, and providing product support. I understand that in some cases, information disclosed under this authorization may be re-disclosed and no longer protected by federal or state privacy laws. I understand that I may refuse to sign this authorization, and my treating providers and health plans may not condition current or future treatment, payment, or eligibility for benefits on my provision of this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at anytime by mailing a letter requesting such cancellation to BioLinx, 6931 Arlington Rd, Suite 308, Bethesda, MD 20814, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires five (5) years from the date signed below. I understand that my pharmacy providers may receive remuneration for disclosing my Personal Health Information pursuant to this Authorization. I further authorize my pharmacy providers to use my Personal Health Information to communicate with me about the drug that has been prescribed for me and understand that they may receive a fee for such communications.

Patient Printed Name: _____

Signature: _____ Date: _____

Phone #: _____

If you are signing this Authorization as a personal representative of the person to receive SUPARTZ therapy, please state your relationship (e.g. "legal guardian"):

Describe Authority to Sign for the Patient: _____

Please fax signed form to 1-855-389–2239
For questions, please call BioLinx toll-free at 1–855–870-0920

bioventus™