PATIENT AUTHORIZATION AND ATTESTATION STATEMENT

My signature authorizes my doctor(s), my healthcare providers, my health plan or payer, and my pharmacy to disclose to Astellas ("Company") and its third-party suppliers, vendors, and other service providers supporting VEOZAH Support Solutions℠ (collectively, the "Service Providers") information about me (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications) (together, "Personally Identifiable Information"). This information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my information pursuant to this authorization.

I understand that VEOZAH Support Solutions is a component of Astellas Pharma Support Solutions℠ and that the Service Providers may be compensated by Astellas. The Service Providers will use and give out my information to:

(i) Assist in my enrollment in VEOZAH Support Solutions and to contact me and/or the person legally authorized to sign on my behalf;
(ii) Provide me and/or the person legally authorized to sign on my behalf with educational and other materials, information, and support related to VEOZAH Support Solutions;
(iii) Verify, investigate, assist with, and coordinate my coverage for VEOZAH™ (fezolinetant) with my payer;
(iv) Coordinate prescription fulfillment;
(v) Assess my eligibility for patient assistance and/or benefits, if necessary;
(vi) Make referrals to other independent programs or alternate sources that may be available to provide assistance to me as allowed under the law, if necessary; and
(vii) Assist with analyses of the efficiencies and performance of services provided by Service Providers.

In some instances, the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes.

I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws.

This authorization will last for three (3) years from the date below or until I am no longer receiving VEOZAH™ (fezolinetant) or enrolled in VEOZAH Support Solutions℠, whichever is later. I do not have to provide this authorization, but if I do not, I will not be able to have my insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of VEOZAH Support Solutions. My choice as to whether to provide this authorization will not change the way my doctors, healthcare providers, or payers treat me. If I no longer wish to participate in VEOZAH Support Solutions, I shall inform my healthcare providers and/or the administrators of VEOZAH Support Solutions in writing that I do not want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. I have the right to revoke or cancel this authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of VEOZAH Support Solutions. Cancellation of this authorization will be valid when received by the administrators of VEOZAH Support Solutions. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I know I have a right to see or copy the information my healthcare providers or payers have given to the Service Providers.

If an application is submitted to determine my eligibility for assistance from the Astellas Patient Assistance Program (PAP), I agree to allow Company and Service Providers to use my demographic information, including, but not limited to, Social Security number, date of birth, name, and/or address, as needed to access my credit information and information derived from public and other sources, including information from a consumer reporting agency (credit bureau), to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the PAP. Company and Service Providers reserve the right to ask for additional documents and information at any time. I affirm that I will not seek to have this medicine or any cost from it counted in my out-of-pocket expenses for prescription drugs. I will not seek reimbursement or credit for

the medicine(s) from my prescription insurance provider. I understand that any medicine provided for free must not be sold, traded, bartered, or transferred.

If your application is approved, VEOZAH Support Solutions℠ can send you text messages about the Program throughout your enrollment period. These text messages are optional. You can participate in the Program without signing up for text messages. When you sign up for the text messages (by providing your cell phone number), you must agree to the following conditions:

- Program will send an autodialed, pre-recorded text message (standard text message and data rates apply).
- You can opt out at any time by calling 1-800-239-1637 or replying "STOP" to the text messages.
- Program is not responsible if a communication is not delivered due to technical difficulties like server issues, phone carrier outages, or discontinued service.
- Be aware that anyone who can open or have access to your phone might see your text messages.
- If your mobile operator is not participating in text messaging services, you will not receive text messages.
- These text messages are NOT reminders to take your medication. You are responsible to take your medication as prescribed.
- Do NOT report product complaints or adverse events (like side effects) by text message. To report these, please call VEOZAH Support Solutions at 1-800-239-1637.
- To receive text messages, you must provide your cell phone number.

By signing the form, I affirm that my answers are complete, true, and accurate to the best of my knowledge. I agree to notify my healthcare providers and VEOZAH Support Solutions if I become aware of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residency. I understand that Astellas reserves the right to change or cancel Astellas' assistance programs, or terminate my enrollment, at any time.

Astellas is committed to the safety and effectiveness of our products. In the event you experience an adverse drug event or side effect, Astellas requests your consent to be able to contact you, your family member, and/or your healthcare provider. This contact may be via

phone, email, or any commonly used electronic form or medium. The purpose of this follow up is to help us at Astellas to better understand the event you experienced in relation to our product.

For additional information regarding how Astellas handles personal information, please visit our Privacy Policy link at: https://www.astellas.com/us/privacy-policy.

This Authorization and Attestation Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

Patient Signature

By signing below, I certify that I have read, understand, and agree to the Patient Authorization and Attestation Statement.

Patient Name (please print): ____

Patient Signature: ________________________________ Date: __________________

Representative Signature

If this Patient Authorization and Attestation Statement is being signed by a representative, please describe the representative's authority to act on behalf of the patient:

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- ☐ I attest that I am completing this form on behalf of the patient, and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have a valid power of attorney to act on behalf of the patient.

Representative Name (please print): ____

Representative Signature: ___________________________ Date: __________________

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