

PATIENT AUTHORIZATION (REQUIRED if "Prescription Order" has been requested above)

I understand that in order for Organon LLC, a subsidiary of Organon & Co. ("Organon") and Lash (the company that will conduct reimbursement support on behalf of Organon) to provide me with assistance, Lash and its administrators (collectively, "Lash") will need to obtain, review, use, and disclose my personal health information related to my treatment with NEXPLANON® (etonogestrel implant), information on my request form, and any prescription for NEXPLANON (my "PHI"). I authorize my physician, pharmacy(ies), and my health plan(s) to disclose my PHI to Lash as necessary to complete the insurance investigation process. I further authorize Lash and the Specialty Pharmacies (Accredo Health Group Inc., AllianceRx Walgreens Prime, ASPN Pharmacies, LLC, CVS Specialty Pharmacy, Humana Specialty Pharmacy, or Magellan Rx Pharmacy) and their respective affiliates to exchange my PHI to provide support and to disclose the information to my health plan(s) and their contractors for the purpose of coordination of benefits, reimbursement support, investigating insurance coverage and coordination of the delivery, receipt and storage of my prescription medication for NEXPLANON for the sole purpose of administration to me by my prescribing provider named above.

I authorize the Specialty Pharmacy to use my PHI to contact me via mail, telephone, text, or email in connection with information related to this Enrollment Form. If contacted by the Specialty Pharmacy via text, I understand that standard data rates apply. In order for the Specialty Pharmacy to ship my prescription medication for NEXPLANON directly to my prescribing provider, I authorize the Specialty Pharmacy to communicate with my prescribing provider about my PHI in order to coordinate the delivery, receipt, and storage of my prescription medication for NEXPLANON for the sole purpose of administration of my prescribing provider at my next scheduled appointment. If there is a \$0 co-pay, signature below serves as my consent for the Specialty Pharmacy to ship my prescription medication to my prescribing provider. I understand that my PHI disclosed pursuant to this Authorization may no longer be protected by certain federal privacy laws and may be re-disclosed by the recipient, but that Lash has agreed to use my PHI only for the purposes described herein.

I understand that if I do not sign this Authorization, that will not affect my receipt of treatment (including with NEXPLANON) or of health insurance benefits, but that I will not be able to obtain certain assistance provided by Lash on behalf of Organon. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to CSCN, PO Box 220523, Charlotte, NC 28222. I understand that canceling my Authorization will not affect uses and disclosures of PHI already made in reliance on the Authorization before my cancellation is received by Lash.

If I do not cancel this Authorization, the Authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). Organon has retained Lash and the Specialty Pharmacies to provide support to customers, including reimbursement support. Information and questions related to the information provided in regard to this request should be referred directly to Lash. Organon personnel are not aware of patient-specific reimbursement information and are not permitted to discuss such information with customers. I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Patient Date of Birth: _____

Relationship to patient if signing on their behalf: _____

If you have questions about completing this form or need additional information, please call 844-NEX-4321 (844-639-4321). Thank you.