ForgingBridges® Support Program Patient Consent and Authorization

Attruby® (acoramidis) 356 mg tablet

forging bridges®

To participate in ForgingBridges and begin receiving the benefits of the program, patients must carefully review the information below and sign where indicated to consent to enroll in the program and authorize to share Protected Health Information (PHI). Once the patient has signed, prescribers should print the form and fax it to **1-877-738-0545**.

Please note: Patient signature is required for enrollment in ForgingBridges.

Please read the following consent and authorization carefully, and if you agree, sign and date where indicated below. You may keep a copy of this form for your records.

ForgingBridges Support Program Patient Consent

By signing below, I am agreeing to the terms and conditions for my enrollment in the ForgingBridges Support Program (the "Program"). I authorize BridgeBio Pharma Inc. ("BridgeBio"), the sponsor of the Program, and its affiliates, business partners, vendors, and other agents to provide me with services for which I am eligible under the Program. This may include medication and adherence communications and support, medication fulfillment and dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to the terms of enrollment in the Copay Assistance Program if I am eligible. If I am applying for the Patient Assistance Program, I authorize the Program to obtain a report on my individual income from consumer reporting agencies and to use information provided by me as sources to verify the information on this form to determine if I am eligible for free medication. I understand that, upon my request, the Program will provide me with the name and address of the consumer reporting agency that delivers any such consumer report. I authorize BridgeBio to contact me by mail, telephone, email, and if I grant my consent below, also by text regarding: i) Program services; ii) information about BridgeBio's products; iii) promotions; iv) research studies; v) my opinion about such information and topics; vi) market research; and vii) disease-related surveys. I further authorize BridgeBio to de-identify my information and use it in performing research, education, business analytics, and marketing studies or for other commercial purposes. I understand I do not have to enroll in the Program, and I can still receive my medication as prescribed by my physician. I may at any time opt out of individual services offered by the Program or opt out of the Program entirely by notifying a Program representative by calling 1-888-55-BRIDGE (1-888-552-7434) or by writing to ForgingBridges at PO Box 15600, Pittsburgh, PA 15244. I understand the Program may be changed or discontinued in whole or in part by BridgeBio at any time.

ForgingBridges authorization to share PHI

By signing below, I authorize my healthcare providers and staff, my pharmacies, and my health insurers to disclose to BridgeBio Pharma Inc. and its affiliates, business partners, vendors, and other agents involved in the ForgingBridges Support Program (the "Program") information identifiable to me, including (i) my contact information; (ii) my health information, such as information on my medical condition and treatment; (iii) health insurance and coverage claims; and (iv) prescription fulfillment information (collectively, my "Information"), to facilitate my receipt of benefits from the Program. I further authorize the Program to use my Information and to discuss it with my healthcare providers and insurers, as needed to enroll me in support programs, provide services, and conduct quality assurance and other administrative activities, and to contact me by mail, telephone, email, and if I grant my consent below, also by text, regarding: i) Program services; ii) information about BridgeBio's products; iii) promotions; iv) research studies; v) my opinion about such information and topics; vi) market research; and vii) disease related surveys. I further authorize BridgeBio to de-identify my information and to use the de-identified information in performing research, education, business analytics, and marketing studies or for other commercial purposes. I understand that, once my Information has been disclosed to the Program, certain federal privacy laws may no longer protect the Information from further disclosure. However, I also understand BridgeBio intends to use and disclose my Information only for the purposes referenced in this authorization or as otherwise required or permitted by law. I understand the pharmacy that dispenses my medication may receive payment from BridgeBio in exchange for my information and/or for providing support services to me in relation to the Program. I understand I do not have to sign this authorization in order to obtain medical treatment from my healthcare providers, to be eligible for health insurance benefits, or to obtain BridgeBio's medications. However, if I do not sign this authorization, I understand I will not be able to participate in the Program. I understand that this authorization expires 10 years from the date signed below, or earlier as may be required by state or local law, and until I cancel this authorization before then. I may cancel this authorization at any time by calling 1-888-55-BRIDGE (1-888-552-7434) or by writing to ForgingBridges at PO Box 15600, Pittsburgh, PA 15244. I understand that cancellation of this authorization will not invalidate any uses and disclosures of my information made in reliance on the authorization before ForgingBridges' receipt of the cancellation. I understand I may request a signed copy of this authorization.

Patient Name: _____ DOB: _____

Patient Address: _____

Email Address: _____ Mobile Phone: _____

Physician Name: _____

☐ By checking this box, I agree to receive communications (phone, text, or email) from a Patient Access Liaison (PAL).

SIGN Patient Signature: _____ Date: _____

If signed by authorized patient representative:

Authorized Patient Representative Name: _____

Email Address: _____ Mobile Phone: _____

☐ By checking this box, I agree to receive communications (phone, text, or email) from ForgingBridges and a Patient Access Liaison (PAL) on behalf of _____

Authorized Patient Representative Signature: _____ Date: _____

☐ **Marketing consent (optional):** By checking this box, you agree to share your contact and certain health information with BridgeBio, its affiliates, and companies working with BridgeBio or its affiliates (collectively, "BridgeBio"). You authorize BridgeBio to contact you by mail, email, phone, fax, text (including autodialed/prerecorded), or digital media for marketing purposes about BridgeBio products, services, or offers. This marketing consent is not required to buy products or participate in the ForgingBridges program. You may opt out anytime. See our Privacy Policy for details.

Please **click here** for the ForgingBridges Support Program Terms and Conditions.

Questions? Call ForgingBridges at
1-888-55-BRIDGE (1-888-552-7434)
Mon–Fri, 8 AM to 8 PM ET
or visit **ForgingBridges.com**

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