SYNDROS™
(dronabinol) oral solution, CII

INSYS - Patient and Health Care Provider Consent Form

Preferred Pharmacy Name: _____ Pharmacy Fax Number: _____

INSYS PRESCRIBER CONSENT: (Please read carefully):

I authorize INSYS Therapeutics to be my designated agent and act as my business associate (as defined in 45 CFR 160.103, "BA") to use, disclose, and receive any protected health information (as defined in 45 CFR 160.103, "PHI") about any of my patients enrolled with the INSYS Patient Services Center or related INSYS programs ("Patients"), including disclosure to any pharmacies, insurance plans or insurer(s) and other third parties to perform the following services: (i) verifying or coordinating insurance coverage or obtain payment for my Patients' treatment with INSYS medications; (ii) coordinating my Patients' treatment with INSYS medications; and (iii) facilitating my patients' access to INSYS medications. INSYS may also use and disclose such PHI to assist my Patients with other functions related to Patients' treatment, payment and/or health care operations, and as otherwise permitted or required by law, including de-identifying any PHI if the de-identification complies with 45 CFR 164.514(b). As my BA, INSYS agrees that it has reviewed, is familiar with and will comply with the requirements of 45 CFR 164.502(e)(2)(ii)(A)-(J) and 45 CFR 164.314(a)(2)(i)(A)-(D), each of which is expressly incorporated herein. INSYS agrees to safeguard any PHI it obtains through this BA relationship and will use and disclose this PHI only as permitted herein. INSYS acknowledges that, if it materially breaches its obligations, I may terminate this BA agreement. I may revoke this authorization at any time, except to the extent action may have already been taken based on this, to pasmanagement@insysrx.com.

I attest that this patient has (one of the following must be checked):

☐ ***Anorexia associated with weight loss in patients with AIDS and the patient is 18 years of age or older***

☐ ***Nausea and Vomiting associated with cancer chemotherapy and has failed to respond adequately to conventional antiemetic treatment and the patient is 18 years of age or older***

☐ ***Attestation not applicable or declines to state and the patient is 18 years of age or older***

Prescriber Name (please print): _____ Prescriber NPI: _____

Prescriber Signature: _____ Date: _____

INSYS PATIENT AUTHORIZATION AND CONSENT TERMS: (Please read carefully):

I authorize my healthcare providers (including my doctor(s) and their staff), my pharmacies, my employer and my health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Personal information") to INSYS Therapeutics Inc. (including sales personnel, account managers, patient support staff and nurses), its affiliates, business partners, and agents (together, "INSYS") so that INSYS can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with INSYS product(s), (ii) coordinate my receipt of, and payment for INSYS product(s), (iii) facilitate my access to INSYS product(s), (iv) provide me with information about the appropriate use of INSYS product(s), disease awareness and clinical care management programs and educational materials (together, the "Support Program"), and (v) conduct market research, data analytics, quality assurance, resource allocation, and other internal business activities. I understand this may include confidential information including information related to, if applicable, my **HIV status and the fact that I have taken drugs prescribed for the treatment of HIV/AIDS**. I authorize INSYS to disclose my Personal information to any pharmacies, my insurance insurer(s), healthcare providers (including my doctor(s) and their staff) and other third parties for the purposes described above. I authorize INSYS to contact me directly for the purposes described above. I understand that I may choose the dispensing pharmacy in accordance with my insurance and/or prescriber recommendation. I agree to receive telephone calls, emails, and mailing materials from INSYS at the telephone number(s) and address(es) provided on this Authorization Form. I understand that my cell phone carrier's standard rates may apply for calls to my cell phone. I understand and agree that Personal information transmitted by email and cell phone cannot be secured against unauthorized access. I understand and agree that my pharmacy, health insurance company and healthcare providers may receive remuneration from INSYS Therapeutics Inc. in exchange for disclosing my Personal information to INSYS Therapeutics Inc. and/or for providing me with therapy support services subsidized by INSYS Therapeutics Inc. I understand that once my Personal information is disclosed it may no longer be protected by federal or state law regarding patient privacy. INSYS will take commercially reasonable steps to ensure the security and privacy of my Personal information. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect the commencement, continuation, or quality of my treatment by my doctor(s); however, if I do not sign or revoke this authorization, I may no longer be eligible to participate in any support program(s) offered by INSYS. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that any support program(s) offered by INSYS may be changed or ended at any time without prior notification. I understand that I may receive a copy of this authorization. Withdrawal of this authorization will end further uses and disclosures of my Personal information by INSYS, except to the extent those uses or disclosures have been made in reliance upon this authorization. I may send my request to revoke this authorization at any time, except to the extent action may have already been taken based on this, to 1333 S Spectrum Blvd #100, Chandler 85286.

Patient Name (please print): _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

Patient Phone Number (required): _____

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