Complete and fax with Patient Referral and Prescription form to 1-866-949-2469

cimplicity™ HIPAA Patient Authorization Form

Patient Authorization to Use/Disclose Health Information

I hereby authorize each of my physicians, pharmacists (including any specialty pharmacy that receives my prescription for CIMZIA® [certolizumab pegol]), and other healthcare providers (together, "Providers"), and each of my health insurers (together, "Insurers") to disclose my protected health information, including but not limited to information related to my medical condition and treatment (including prescription information), my health insurance coverage, my name, address, telephone number, Social Security number, and insurance number (together, "Protected Health Information"), to UCB, Inc. and its agents and representatives (including RxCrossroads®) (together, "UCB"), for the purposes described below.

Specifically, I authorize UCB to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me about, CIMZIA support programs; (ii) provide me with educational materials, information, and services related to CIMZIA; (iii) verify, investigate, assist with, and coordinate my coverage for CIMZIA with my Insurers; (iv) conduct market analyses or other commercial activity, including aggregating my Protected Health Information with other data for such analyses; (v) assist with analysis related to quality, efficacy, and safety for CIMZIA; and (vi) deidentify my Protected Health Information for use for any purpose under applicable law. UCB may also further use and disclose my Protected Health Information as required or permitted by law. I understand that once my Protected Health Information has been disclosed to UCB, federal privacy laws may no longer protect the information and that my Protected Health Information may be subject to re-disclosure.

I understand that I am not required to sign this Authorization. If I do not sign, my treatment (including the receipt of CIMZIA), payment for treatment, insurance enrollment, or eligibility for insurance benefits, will not be directly affected, but I will not be eligible for enrollment in CIMZIA support programs and may not receive the other services described above.

I understand that I may cancel (revoke) this Authorization at any time by mailing a letter requesting such revocation to: CIMplicity, c/o RxCrossroads, Inc., PO Box 18708, Louisville, KY 40261. UCB shall provide timely notification of my cancellation (revocation) to my Providers and Insurers. Once my Providers and Insurers receive and process the notice of cancellation (revocation) of this Authorization, my Providers and Insurers may no longer make disclosures of my Protected Health Information to UCB. However, canceling this Authorization will not affect UCB's ability to use and disclose Protected Health Information that it has already received (unless the laws of my state prevent UCB from continuing to use and disclose such Protected Health Information).

This Authorization expires: December 31, 2020 ❑ Other:

I understand that I have a right to receive a copy of this Authorization.

Patient name:

Signature of patient and/or legal representative: Date:

Print name of patient and/or legal representative:

Describe legal representative's relationship to patient:

Please see accompanying full Prescribing Information.

For more information, contact the cimplicity™ service center:

Hours 8:00 AM to 8:00 PM, EST, Monday through Friday Fax 1-866-949-2469
Phone 1-866-4-CIMZIA (1-866-424-6942) Web site www.cimzia.com

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