AkebiaCares patient consent form

Patient HIPAA Authorization to use and share protected health information

By signing below, I authorize my healthcare professionals, including my physicians and pharmacies ("My Providers"), and my health insurance plan ("My Plan") to use and share my identifiable medical information (such as information about my diagnosis and treatment) and my identifiable insurance information (collectively, "My Information") with Akebia Therapeutics, Inc., and its subsidiaries (including Keryx Biopharmaceuticals, Inc.), affiliates, representatives, agents, and contractors ("Akebia") so that Akebia can: provide me with information, assistance, and support through AkebiaCares ("Patient Support") as described below; administer and analyze the effectiveness of AkebiaCares; ask if I am interested in participating in clinical trials and market research; review eligibility for financial assistance; carry out other business purposes related to Akebia products; and comply with law. I understand and agree that my pharmacies may receive payment from Akebia in exchange for sharing My Information with Akebia. Once My Information has been shared with Akebia, federal privacy laws may no longer protect the information. However, Akebia agrees to protect My Information by using and disclosing it only for the purposes described in this authorization. I may refuse to sign this authorization and doing so will not affect my treatment, insurance coverage, or eligibility for benefits for which I am otherwise entitled. However, refusing to sign this authorization means that I cannot participate in AkebiaCares.

I may cancel or revoke this or any portion of this authorization at any time by:

- Mailing a letter to AkebiaCares, P.O. Box 5490, Louisville, KY 40255
- Sending an email to support@akebiacares.com

If I revoke or limit this authorization, My Providers and My Plan will stop using and sharing My Information, but my revocation will not affect uses and disclosures of My Information made in reliance upon this authorization prior to my revocation. This authorization expires ten (10) years from the date signed below, or earlier if required by state or local law, unless I revoke it before then. I will receive a copy of my signed authorization.

Print patient or authorized patient representative name

Relationship to patient

Signature of patient or authorized patient representative

Date

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Patient consent to participate in AkebiaCares

AkebiaCares is a program administered by Akebia that provides Patient Support to eligible patients who have been prescribed an Akebia medication. Patient Support includes:

1. Providing reimbursement and assistance with financial support (including, but not limited to, investigating insurance coverage, confirming out-of-pocket costs, and reviewing eligibility for financial assistance);
2. Working with patients and their healthcare professionals to fill their prescriptions; and
3. Providing patients with disease and medication-related educational resources and communications.

I acknowledge that Akebia may use My Information and share it with My Providers or My Plan in connection with providing Patient Support and for the other purposes described in the authorization above. I expressly permit Akebia to:

1. Contact me or my representative, using contact information that I provide, through any medium, including, but not limited to, mail, telephone, text message, or email;
2. Use My Information to tailor AkebiaCares-related communications to my needs; and
3. Share information with My Providers about dispensing an Akebia product to me.

Akebia may also de-identify My Information and use the de-identified information for Akebia's business purposes. I understand that AkebiaCares is an optional program and that my treatment, insurance enrollment, and insurance eligibility are not conditioned upon providing consent. I also understand that refusing to consent will make me ineligible to participate in AkebiaCares.

If I provide consent, I may revoke it at any time by:

- Mailing a letter to AkebiaCares, P.O. Box 5490, Louisville, KY 40255
- Sending an email to support@akebiacares.com
- Following the opt-out instructions in any correspondence that I receive

If my contact or insurance information changes at any time while I am participating in AkebiaCares, I will notify AkebiaCares as soon as possible by using the physical or email address provided above. By signing below, I confirm that I would like to enroll in AkebiaCares and that I want Akebia to provide me with Patient Support. By signing below, I also authorize the Centers for Medicare & Medicaid Services to disclose Medicare eligibility information to Akebia.

If I am applying for financial assistance, I also agree that Akebia can use the information provided on this form or otherwise provided by me directly or through My Providers (including my Social Security number, household information, and household income) to obtain credit reports about me from credit reporting agencies in order to verify the information, estimate my income, and determine my eligibility for financial assistance. Regardless of whether a credit report is obtained, Akebia has the right to require written proof of income (such as a Form 1040, Form W-2, or other documentation) from me in connection with a financial eligibility determination.

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☐ Opt-in to Receive Marketing Communications (optional): By checking this box, I authorize Akebia, and companies working with Akebia, to contact me regarding product and educational information, and for other opportunities, including, but not limited to, customer surveys. I understand that I am not required to provide this consent as a condition of receiving any Akebia medicine or services from Akebia.

I understand that I may opt-out of these communications at any time via the link/contact information available in all communications.

Print patient or authorized patient representative name

_____

Relationship to patient

_____

Signature of patient or authorized patient representative

_____

Date

_____

For details about how we collect and use personal information, including applicable U.S. state privacy rights and notices for California residents, please visit https://akebia.com/privacy-policy/.