bymyside™ Patient Authorization Form

myalept® (metreleptin) for injection 11.3 mg per vial

The purpose of this Authorization form is to permit ByMySide participants to receive additional disease education and information ("Patient Support") from Aegerion Pharmaceuticals, its affiliates, representatives, agents and contractors ("Aegerion"). Please read this form carefully and ask any questions that you may have.

To be read, completed, and signed by patient or patient's personal representative.

PLEASE FAX TO 1-877-328-9682

I. AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

By signing this Authorization, I authorize Accredo Specialty Pharmacy ("Accredo") to disclose my contact information and protected health information (or "PHI") related to my disease management, including but not limited to my name, medical and pharmacy records and information relating to payment for my disease management, care management and health insurance, as well as all information provided on any Myalept prescription or prescription related to my disease management, to Aegerion Pharmaceuticals, Inc., and those working on its behalf (collectively, "Aegerion") to provide the Patient Support.

II. PURPOSE OF AUTHORIZATION

The purpose of this Authorization to enable me to obtain patient support from Aegerion, including:

- Investigation of my insurance coverage
- Coordination of benefits and reimbursement support
- Investigation of financial support services and programs, or comparable programs for Myalept that may help me
- Facilitating claims adjudication and submission of claims to third party payers for payment
- Education and access to patient programs related to my disease management including medication adherence support, nutrition support and access to a registered dietitian, treatment and medication reminders and injection training
- Participation in surveys and quality assessment activities to evaluate the effectiveness of the Patient Support

The Authorization also enables me to receive Marketing communications from Aegerion or those acting on its behalf offering programs, services or products of interest to patients taking Myalept.

Aegerion is authorized to contact me by mail, e-mail, text, telephone, and/or any alternative communication method that I request in connection with the Patient Support.

Once my PHI has been disclosed to Aegerion, I understand that federal privacy laws may no longer protect that PHI. However, Aegerion will take reasonable steps to protect my PHI by using and disclosing it only for the purposes described in this Authorization or as otherwise authorized by law.

I understand that I may refuse to sign this Authorization, and that doing so will not affect my ability to participate in ByMySide or to receive treatment or benefits to which I am otherwise entitled. I understand that I am entitled to a copy of this Authorization, and that I may revoke this Authorization at any time, by mailing a letter requesting revocation to: Accredo Health Group, Inc. c/o The Myalept Program, 1640 Century Center Parkway Memphis, TN 38134.

I understand that expiration of or revoking this Authorization will end further use and disclosure of my PHI but that it will not affect use or disclosure of PHI that has already been disclosed by Accredo in reliance upon this Authorization.

This Authorization will expire upon my revocation or one year after I receive my last prescription.

AGREED:

Patient Signature: _____ Date: _____

Patient Name (please print): _____

Personal Representative or Guardian Signature (if applicable): _____

Personal Representative or Guardian Name (please print): _____

Relationship to Patient, including the authority for status as Personal Representative: _____

Address of Patient or Personal Representative: _____

Telephone Number: _____ Email Address: _____

Please see accompanying full Prescribing Information including Medication Guide and Boxed Warning.

ByMySide • 1-855-669-2537 (phone) • 1-877-328-9682 (fax)