Case Number:

PATIENT AUTHORIZATION FORM FOR SUPPRELIN® LA

You have expressed an interest in SUPPRELIN® LA therapy. The SUPPRELIN LA Support Center can provide certain services to you and on your behalf during the search for SUPPRELIN LA therapy reimbursement, and during your child's therapy with SUPPRELIN LA. The SUPPRELIN LA Support Center is an agent of Endo Pharmaceuticals Inc., however Endo will not have access to patient specific health information.

In order to provide these Services, the Support Center will need to use your child's health information (called "Protected Health Information" or "PHI"), and to share it with your health plan and the pharmacy that will receive your doctor's prescription. This authorization will allow your healthcare providers, health plans, and health insurers that maintain PHI about you to disclose your PHI to the Support Center so that the Support Center may provide these Services to you, or on your behalf.

Authorization and Signature:

By signing this Authorization, I authorize my physician, health plans and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to the Support Center and its representatives, agents, and contractors for the following purposes: (1) to establish my eligibility for benefits; (2) to communicate with my healthcare providers and me about my medical care; and (3) to facilitate the provision of products, supplies or services by a third party including, but not limited to specialty pharmacies and (4) to register me in any applicable product registration program required for my treatment. I understand that my Personal Health Information disclosed under this Authorization may no longer be protected by federal privacy law and may be re-disclosed by the Support Center. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits are not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to the SUPPRELIN LA Support Center, 9717 Key West Avenue, Rockville, MD 20850, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires five (5) years from the date signed below.

Signature: ____ Date:_____________________

Patient's Printed Name: ___________________________________

If you are signing this Authorization as a personal representative of the person to receive SUPPRELIN® LA therapy, please state your relationship (e.g., "mother," "father," "legal guardian"):

Relationship: _______________________________________

Please fax signed form to (888) 882-4037

For questions, please call

The SUPPRELIN® LA Support Center toll-free at 1-800-462-ENDO (3636)

CHADDS FORD PENNSYLVANIA 19317

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