Commercial Access Program
Patient Designee Form

Lucemyra® (lofexidine) tablets 0.18 mg

Customer Service: (844) 439-2433 | Fax completed form to: (877) 202-9926

By signing below, I authorize my Designee(s), listed below, to receive from and provide health information to Asembia, LLC, ASPN Pharmacies, LLC (collectively, "Asembia"), and their network of dispensing pharmacies related to my Lucemyra® prescription, and to make decisions on my behalf – for which I remain liable – regarding prescription delivery (the "Program"). US WorldMeds, Asembia, and its network of dispensing pharmacies are not liable for any decision(s) made by the Designee(s) or actions taken in reliance on such Designee(s) decisions.

This health information may include spoken or written facts about my medical condition, my health insurance benefits, name, date of birth, address, telephone number(s,) social security number, and/or financial information. All or some of this information may be considered protected health information ("PHI"), as governed and protected by the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, as amended, and the rules and regulations thereunder.

I understand and acknowledge that people who work for and with Asembia and its network of dispensing pharmacies may receive and use my information, but that they may use it only as authorized in this form or for such purposes as may be required by applicable law. I understand that Asembia and its network of dispensing pharmacies will keep my information private and use and disclose it only as allowed on this form. I understand that, once my information is disclosed to the intended recipients, it may be further disclosed by said recipient(s), and federal privacy laws will not protect it if the entities receiving the information are not subject to those laws. For California Residents: California law prohibits the person receiving your health information from making further disclosure of it, unless another authorization for such additional disclosure is obtained from you or unless such disclosure is specifically required or permitted by law.

I may withdraw my authorization at any time by mailing a written request to Lucemyra Commercial Access Program, 200 Park Avenue, Florham Park, NJ 07932; faxing a written request to 1-844-805-8885; or calling 1-844-805- 8884. Withdrawal of my authorization will end further uses and disclosures of my information by the parties identified in this form, except to the extent those uses and disclosures have been made in reliance upon this authorization and as permitted by applicable law. My authorization expires five (5) years from the date indicated below unless I withdraw it earlier.

I understand and acknowledge that I may refuse to sign this form. My choice about whether or not to sign this form will not change the way my healthcare providers treat me. However, I understand that my refusal to sign this form may preclude or limit my participation in the Program. I understand that Asembia and its network of dispensing pharmacies do not promise to find ways to pay for my medication(s) and that I am responsible for the costs of my care. I agree that a copy of this form may be

Please list all authorized designees:

Designee name (1): Relationship: Phone:

Designee name (2): Relationship: Phone:

Patient Name: Date of birth:

Patient's Signature Date of signature:

*Parent/Guardian/Legal Representative name: Authority/relationship to patient:

*Parent/Guardian/Legal Representative Signature: *Date of signature:

*If patient is without capacity to act alone under state law, signature of patient and parent/guardian/legal representative is required.

US WorldMeds®