Talicia®
(omeprazole magnesium, amoxicillin, and rifabutin) delayed-release capsules

Talicia® Warranty Program
Patient Declarations and Authorization Form
(To be completed by the patient or authorized patient representative)

PLEASE READ THE FOLLOWING AND SIGN WHERE REQUESTED. FAILURE TO COMPLETE THIS FORM MAY DELAY THE PROCESSING OF YOUR CLAIM.

Patient Consent for Talicia Warranty Program

The information you provide will be used by Apollo Rx, LLC ("Apollo Care"), authorized third-party administrator for RedHill Biopharma, to determine eligibility, to administer warranty claims, to manage and improve the Talicia Warranty Program, to communicate with you about the Talicia Warranty Program, and/or to send you materials and other helpful information and updates relating to the Talicia Warranty Program.

By signing this form:

I understand the following:—Completing the Patient Declarations and Authorization Form does not guarantee that I will qualify for the Talicia Warranty Program. Apollo Care may contact my health insurer to administer the Talicia Warranty Program. Apollo Care may verify the accuracy of the information I have provided and may ask for more insurance information. RedHill Biopharma reserves the right to change or cancel the Talicia Warranty Program at any time. Should RedHill Biopharma change or cancel the program, it will continue to honor valid warranty claims related to qualifying doses of Talicia dispensed during the period in which the program remained in effect. Any benefits provided under the Talicia Warranty Program are not contingent on any future purchase.

I certify and attest to the following:—I have a signed copy of a current and completed HIPAA Authorization Form on record with my healthcare provider ("HCP") so that my HCP may share health information about me with the Talicia Warranty Program. By signing the form, I affirm that my answers are complete, true, and accurate to the best of my knowledge, and I meet all the eligibility and terms and conditions of the Talicia Warranty Program posted at talicia.com.

Patient Consent to Receive Communications

I agree to communications from Apollo Care to determine my eligibility, administer warranty claims, and for other non-marketing purposes. I agree to be contacted by Apollo Care for these purposes, including using an auto-dialer or prerecorded voice at the telephone number(s) provided. If I have an Authorized Patient Representative, he or she has also agreed to receive such communications from Apollo Care for the purposes described above, and I hereby give my permission for Apollo Care to contact my Authorized Patient Representative for such purposes. I understand that I (and, if applicable, my Authorized Patient Representative) can opt out of these communications at any time by emailing talicia.warranty@apollocare.com.

Patient Authorization to Share Health Information

I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Apollo Care. I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth).

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My health information will be shared with Apollo Care so that Apollo Care may determine my eligibility for and, if eligible, provide me a warranty payment under, the Talicia Warranty Program.

Apollo Care also may use my information for Talicia Warranty quality assurance purposes and to evaluate and improve operations and services.

I understand that I do not have to sign this form and choosing not to sign will not affect my ability to receive treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, I will not be eligible for the Talicia Warranty Program.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Apollo Care agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law.

I understand that this form will remain in effect for 4 years from the date of my signature unless I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician, or I may contact Talicia.warranty@apollocare.com.

This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

I give my permission to receive communications from Apollo Care, including calls made with an auto-dialer or prerecorded voice at the phone number(s) provided to determine my eligibility for the Talicia Warranty Program, administer warranty claims, and for other non marketing purposes. If I have an Authorized Patient Representative, he or she has also agreed to receive such communications from Apollo Care and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Apollo Care to contact my Authorized Patient Representative for such purposes. I understand that I (and, if applicable, my Authorized Patient Representative) can opt out of these communications at any time by contacting Apollo Care at Talicia.warranty@apollocare.com.

I declare that, to the best of my knowledge and belief, all of the information provided in support of this claim is complete, true and accurate. I attest that I completed a full course of treatment of Talicia as instructed. I understand that if I made or shall make any false or fraudulent statements or withhold material facts relating to this claim, this could result in the forfeiture of my benefits.

I understand that information related to my claim may be disclosed to and used by Apollo Care for the purpose of processing my claim for benefits. I authorize disclosure of any and all information about the Talicia Warranty Program in order to process my benefits including any insurance covering the Talicia Warranty Program. I understand that Talicia Warranty Program information disclosed pursuant to this authorization may be used or disclosed to third parties to evaluate, process, or facilitate my claim for benefits including recovery of monies due from insurers, if any.

I will provide, to the best of my knowledge, information about all insurance and third-party payments for Talicia to ensure accurate claims payments.

Acknowledgement of State Insurance Laws

For residents of all states except those states and territories noted below:
WARNING: Any person who knowingly and with the intent to injure, defraud, deceive any insurance company or other person, who files a statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to criminal prosecution, civil penalties and forfeiture of insurance benefits.

For residents of WASHINGTON D.C., MAINE, TENNESSEE, VIRGINIA, and WASHINGTON:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

For residents of ARKANSAS, KENTUCKY, LOUISIANA, NEW MEXICO, PENNSYLVANIA, RHODE ISLAND, TEXAS, and WEST VIRGINIA:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under this title.

ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or Card Member for the purpose of defrauding or attempting to defraud the policyholder or Card Member with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE, IDAHO, and OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

INDIANA: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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Complete and Sign Here

Patient Signature: _____

Print Patient Name: _____

Date: _____

Authorized Patient Representative Signature: (if applicable) _____

Print Patient Representative Name: (if applicable) _____

Date (if applicable): _____

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