TO BE FILLED OUT AFTER TAKING SUCRAID® FROM LOT NUMBER D0401 RELEASED DURING SUCRAID® SHORTAGE

PATIENT QUESTIONNAIRE

Sucraid® (sacrosidase) Oral Solution May Be Completed by the Patient or Patient's Parent or Guardian

Patient name_____ **DOB**: _____ **Phone:**_____
Parent/Guardian name (if not completed by patient) _____**Date**_____
Lot Number of Sucraid®: _____

1. **When did you first start taking Sucraid® (any lot)?**
   Month: _____ Year: _____

2. **Before you started taking Sucraid®, what were your main symptoms? Check all that apply.**
   - ☐ Frequent diarrhea
   - ☐ Bloating
   - ☐ Constipation
   - ☐ Weight loss
   - ☐ Excessive gassiness
   - ☐ Abdominal cramps or abdominal pain
   - ☐ Other(s) _____

3. **What is your age? _____months old, OR _____years old**

4. **When did you start taking Sucraid® from this lot number D0401?**
   Month: _____Year: _____

Since you started taking the Sucraid® lot number D0401 as indicated in #4:

5. **Have you noticed any increase in your digestive symptoms (as indicated in #2) between previous lots and this lot of Sucraid®?**
   Yes ☐ No ☐

   If yes, what symptoms increased, and how many times each day did you have these symptoms?
   Symptom: _____ How many times each day_____
   Symptom: _____ How many times each day_____
   Symptom: _____ How many times each day _____

6. **Have you experienced any side effects since taking this lot of Sucraid®?**
   Yes ☐ No ☐
   If so, please describe:_____
   _____

7. **Have you noticed a change in the color of this lot of Sucraid®?**
   Yes ☐ No ☐
   If so, please describe:_____
   _____

8. **What other changes have you noticed in this lot of Sucraid®? Check all that apply.**
   - ☐ Change in taste. Please describe_____
     _____
   - ☐ Change in smell. Please describe_____
     _____
   - ☐ Change in something else. Please specify and describe_____
     _____
   - ☐ No change

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9. **Have you noticed any other significant symptoms that you believe are related to this lot D0401 of Sucraid®?** Please describe _____

_____

HIPAA Statement

Authorization to Use and Disclose Protected Health Information ("Authorization"): I authorize my pharmacy, Accredo Health Group, Inc. (Accredo),QOL Medical, LLC, the maker of Sucraid®, One Patient Services, LLC, Sucraid® support service provider, dietary consultants, my physicians, and other healthcare providers, pharmacists, insurers, and any agent or representative of any of these parties (collectively, "Authorized Parties") to obtain individually identifiable health information ("IIHI") regarding me and my medical condition, symptoms, treatments, family medical history, insurance coverage and payment history, and diet, and to collect, use, and disclose my IIHI among each other to/from third parties (which may include insurers, public funding programs, social workers, advocacy organizations, assistance organizations, healthcare providers, dietary consultants, and other persons or entities as any of the Authorized Parties may deem appropriate) to: (1) coordinate my treatment; (2) facilitate reimbursement support and obtain payment for my treatment; (3) provide me and my healthcare providers with free educational materials, dietary support, and/or peer consultation (4) conduct healthcare marketing activities, including those for which Accredo or One Patient Services, LLC receives compensation (5) conduct clinical assessments regarding therapeutic response to Sucraid® and (6) carry out any other purpose required or permitted by law. I understand that any of the Authorized Parties may need to contact me for additional information. For purposes of this authorization, I understand that my IIHI includes any individually identifiable information about me such as my social security number, contact information, medical condition or other health information, and treatment and payment history relating to my past, present, and future use of Sucraid® and other healthcare items or services. I understand that once my information is disclosed under this authorization, it may be further disclosed and no longer protected by federal confidentiality laws. I understand that treatment by my physician and payment, enrollment, or eligibility to receive Sucraid® is not conditioned upon the signing of this authorization. However, if I refuse to sign this authorization, my ability to receive support services related to my use of Sucraid® may be limited. I understand that this authorization will remain in effect until the later of ten (10) years from the date of my signature or five (5) years following my discontinuance of purchase of Sucraid® unless I revoke it by sending written notice to the One Patient Services Manager at One Patient Services, 7003 Presidents Drive, Suite 800, Orlando, FL 32809. If I revoke this authorization, One Patient Services, LLC will communicate my revocation to the Authorized Parties and will stop using and disclosing my information as soon as possible. However, my revocation will not affect any prior use or disclosure of IIHI made in reliance on this authorization and my revocation will not affect my treatment by my physician. If I have questions about disclosures of my IIHI, I may contact the Privacy Officer at One Patient Services at sucraid@onepatientservices.com. I understand that I have the right to receive a copy of this authorization. I further understand that I have the right at any time to refuse nursing support, dietary support or peer consultation.

Patient Name (print)_____Date_____
Patient Signature (or representative)_____Relationship to Patient (if applicable)_____

When you have completed the questionnaire, please send the completed questionnaire by email to sucraid@onepatientservices.com or by mail to (using the postage paid envelope).

Postage paid envelope to:

One Patient Services
2016 Patient Questionnaire
7003 Presidents Drive; Suite 800
Orlando, Florida 32809

Email to: **sucraid@onepatientservices.com**

If you have any questions about this questionnaire, you may call Sucraid*ASSIST*™ at 1-800-705-1962.
Thank you for your time and assistance.