Veloxis PHARMACEUTICALS
an Asahi Kasei company

DESIGNATION OF AGENCY FORM

Please complete and fax to 1-844-475-8931
For assistance or additional information,
call 1-844-VELOXIS, M-F, 9 am - 7 pm EST.

Transplant Support
1-844 VELOXIS (835-6947)

1. SCOPE OF AGENCY

I, _____ (insert prescriber's name), designate the individual(s) listed in Exhibit A ("Permitted Designees") to insert my digital signature to the Veloxis Transplant Support Enrollment Form where applicable. By such individual's provision and upload of my digital signature on my behalf, I acknowledge and certify that I have received authorization from the patient applicant to release the certain patient applicant information provided within the Veloxis Transplant Support Enrollment Form to Veloxis Pharmaceuticals and its service providers, agents, and administrators (collectively, the "Companies") to assist the patient applicant in obtaining access to ENVARSUS XR® (tacrolimus extended-release tablets). The Veloxis Transplant Support ("VTS") program may use and disclose the patient applicant information as necessary to enroll my patient in the VTS program should the patient applicant meet the eligibility criteria. I understand that I am under no obligation to prescribe ENVARSUS XR® and that I have not received nor will receive any benefit from Veloxis for prescribing a Veloxis product. I certify that I have prescribed ENVARSUS XR® for the patient for its FDA approved use based on my independent medical judgment that ENVARSUS XR® is medically necessary for the patient and that all information provided on the form is accurate. I attest that I am not on the HHS/OIG list of Excluded Individuals.

2. TERM OF AGENCY

The term of this Designation of Agency shall become effective as of the date of my signature below and shall continue until I provide written notice of termination of this Designation of Agency to the Veloxis Transplant Support program as set forth in Section 4 (Notice) (collectively, the "Term").

3. EFFECT OF TERMINATION OF AGENCY

Termination of this Designation of Agency shall not affect any communications and/or actions made before the effective termination date. The VTS program shall not be required to inform any third-party of the termination of this Designation of Agency.

4. NOTICE

Notices under this Designation of Agency shall be made to the VTS program at help@veloxistransplantsupport.com.

5. AUTHORIZATION

By signing below and submitting this Designation of Agency, I affirm the above.

Prescriber Name Printed _____ Prescriber NPI # _____

Prescriber Title _____ Prescriber Address _____

X _____ Prescriber Signature _____ Date _____ City _____ State _____ ZIP Code _____

EXHIBIT A: PERMITTED DESIGNEES

1. Name Printed _____ Title _____

Email Address _____ Phone Number _____

2. Name Printed _____ Title _____

Email Address _____ Phone Number _____

3. Name Printed _____ Title _____

Email Address _____ Phone Number _____