VERICEL Cell storage and HIPAA authorization

Background

Your doctor has identified you as a potential candidate for MACI® (autologous cultured chondrocytes on porcine collagen membrane), a treatment for cartilage defects of the knee. MACI is an implant grown from a biopsy of your own cells.

A biopsy of your cartilage cells has been taken and shipped to Vericel Corporation ("Vericel"), the manufacturer of MACI, in Cambridge, Massachusetts. Vericel will store these cells and, should you and your doctor decide to proceed with MACI, Vericel will process the cells into an implant to treat your injury.

To assist you in determining your insurance coverage for MACI, you may choose to enroll in the MyCartilageCare® Program, which is administered by Vericel through its contractor PRO-Spectus. If you and your doctor decide to proceed with MACI, depending on your insurance coverage, MACI may be dispensed by a specialty pharmacy, such as Orsini Specialty Pharmacy or AllCare Plus Pharmacy, or shipped directly from Vericel to the facility at which your MACI procedure takes place.

Scope, Use and Disclosure of Your Health Information

If you choose to sign this Authorization, you authorize your healthcare providers, your health insurance company, pharmacy providers, including Orsini Specialty Pharmacy and AllCare Plus Pharmacy, and the facility at which you are treated to disclose to Vericel Corporation and its respective affiliates, agents, and contracted third parties, including, but not limited to MyCartilageCare (administered via PRO-Spectus), (collectively, "Companies") your protected health information ("Health Information"), for the purposes described below. This Health Information includes all of your medical records related to your possible treatment with MACI, as well as information related to your treatment and insurance coverage (for example, your name, address, phone number, email address, or information about your medical condition or status).

Examples of how your information may be used and/or disclosed if you execute this Authorization, include, but are not limited to, the following:

- to enroll you in the "MyCartilageCare Program," a support resource designed to assist with questions as well as provide assistance regarding insurance;
- to help verify or coordinate insurance coverage or otherwise obtain payment for your treatment with MACI implantation;
- to provide updates regarding the status of your insurance coverage, including reasons for any insurance denial (e.g., body mass index, age), to your healthcare provider and Vericel, specifically including Vericel's field representatives;
- to provide you with educational information related to MACI implantation or similar products that may be of interest to me, including disease awareness and management programs;
- to provide you with support related to your MACI treatment;
- to communicate with your healthcare provider or you regarding the status of your MACI biopsy; and
- in conducting quality assurance, surveys and other business activities in connection with MACI implantation

Authorization

I authorize MyCartilageCare to receive and share my Health Information on my behalf and release to a payer (insurance company), pharmacy provider and/or a treating facility.

I understand that the Companies may contact me by mail, email, text, telephone, and/or any alternative communication method ("Communications") that I request for the purposes described in this Authorization.

I understand that Vericel may pay Companies to provide some of these Communications to me.

I understand that my healthcare providers, insurance company, pharmacy providers, and/or treating facility may receive remuneration in exchange for reimbursement services and/or therapy support services provided to me.

I understand that I am not required to sign this Authorization as a condition to receiving treatment with Vericel's products or reimbursement for treatment; enrolling in a health plan; or establishing eligibility for benefits. However, I also understand that by refusing to sign this Authorization, I will not be able to enroll in or receive certain services provided by the MyCartilageCare Program. I understand that I may refuse to sign this Authorization.

I understand that I should keep a copy of the executed Authorization for my records.

I understand that I may revoke this Authorization at any time by notifying Vericel in writing at the following address:

MyCartilageCare Program
c/o Vericel Customer Care
64 Sidney Street
Cambridge, MA 02139

I understand that the revocation of this Authorization will be effective upon actual receipt of my letter by Vericel at the above address. Revoking this Authorization will end my consent to further disclosure of my Health Information to Vericel and the Companies. If I revoke this Authorization, it will not have any effect on any actions taken by the Companies before the revocation.

I understand that the Health Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient(s), because it may no longer be protected by federal privacy regulations, including HIPAA.

This Authorization expires five (5) years from the date this Authorization is signed (unless a shorter period is required by law).

By executing this Authorization, I certify that I (1) have read this Authorization; (2) understand the Scope and Uses and Disclosure of Your Health Information; and (3) authorize the use and disclosure of my protected health information as described above.

Patient Signature: _____ Patient Name (print): _____ Date: _____

Phone Number: _____ Email: _____

Address: _____

COMPLETE GRAY SECTION ONLY IF APPLICABLE

Personal Representative Signature: _____ Personal Representative Name (print): _____

Relationship to Patient, including the authority for status as Personal Representative: _____

Complete form online at: **MyCartilageCare.com/consent**

SCAN TO PROVIDE CONSENT ONLINE

Form can be submitted via one of the methods below:

INCLUDE COMPLETED FORM
with MACI® biopsy, an additional authorization form is included with MACI Biopsy Transmittal Notice (healthcare providers only)

MAIL COMPLETED FORM TO:
MyCartilageCare® Program
c/o Vericel Customer Care
64 Sidney Street
Cambridge, MA 02139

FAX COMPLETED FORM TO:
855-803-9485

VERICEL

Insurance authorization

PAYMENT AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize AllCare Plus Pharmacy to submit claims on my behalf directly to the applicable third party payor, and hereby authorize, and assign my right to AllCare Plus Pharmacy (or its legal representative) to receive payment from such third party payor. In the event AllCare Plus Pharmacy submits a claim on my behalf and the reimbursement check comes directly to me, I will sign it and endorse the back of the check to read "Payable to the order of AllCare Plus Pharmacy" and will mail such check to AllCare Plus Pharmacy within five (5) working days. I understand that even if a third party payor reimburses AllCare Plus Pharmacy for services provided, I will remain responsible for, and will promptly pay AllCare Plus Pharmacy any applicable co-payment, deductible or other payments for which I am obligated. I acknowledge and agree this assignment shall not extinguish or diminish my obligation to pay the full fee owed to AllCare Plus Pharmacy for services rendered in the event such amount is not reimbursed by a third party payor and, in such event, I agree to promptly make such payment to AllCare Plus Pharmacy.

CONSENT FOR TREATMENT

I understand that my treatment is under the control of my physician, and that AllCare Plus Pharmacy is not acting as my case manager.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature below acknowledges that I have been provided with and agree to the terms of the privacy policies and practices of AllCare Plus Pharmacy set forth in the Notice of Privacy Practices. A copy of the current Notice of Privacy Practices is available at www.allcareluspharmacy.com.

CERTIFICATION

My signature below certifies that I have read this Assignment of Benefits/ Consent and Acknowledgement, that I consent to the payment terms, to participate in the MyCartilageCare® Program and, as described above, to receive certain services and products from AllCare Plus Pharmacy, unless otherwise elected above.

Patient Signature: _____ Patient Name (print): _____ Date: _____

Phone Number: _____ Email: _____

Address: _____

COMPLETE GRAY SECTION ONLY IF APPLICABLE

Personal Representative Signature: _____ Personal Representative Name (print): _____

Relationship to Patient, including the authority for status as Personal Representative: _____

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64 Sidney Street
Cambridge, MA 02139

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VERICEL

Insurance authorization

PAYMENT AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Orsini Pharmaceutical Services, Inc. (Orsini Healthcare) to submit claims on my behalf directly to the applicable third party payor, and hereby authorize, and assign my right to Orsini Healthcare (or its legal representative) to receive payment from such third party payor. In the event Orsini Healthcare submits a claim on my behalf and the reimbursement check comes directly to me, I will sign it and endorse the back of the check to read "Payable to the order of Orsini Pharmaceutical Services" and will mail such check to Orsini Healthcare within five (5) working days. I understand that even if a third party payor reimburses Orsini Healthcare for services provided, I will remain responsible for, and will promptly pay Orsini Healthcare any applicable co-payment, deductible or other payments for which I am obligated. I acknowledge and agree this assignment shall not extinguish or diminish my obligation to pay the full fee owed to Orsini Healthcare for services rendered in the event such amount is not reimbursed by a third party payor and, in such event, I agree to promptly make such payment to Orsini Healthcare.

CONSENT FOR TREATMENT

I understand that my treatment is under the control of my physician, and that Orsini Healthcare is not acting as my case manager.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature below acknowledges that I have been provided with and agree to the terms of the privacy policies and practices of Orsini Healthcare set forth in the Notice of Privacy Practices. A copy of the current Notice of Privacy Practices is available at www.orsinihealthcare.com.

CERTIFICATION

My signature below certifies that I have read this Assignment of Benefits/ Consent and Acknowledgement, that I consent to the payment terms, to participate in the MyCartilageCare® Program and, as described above, to receive certain services and products from Orsini Healthcare, unless otherwise elected above.

Patient Signature: _____ Patient Name (print): _____ Date: _____

Phone Number: _____ Email: _____

Address: _____

COMPLETE GRAY SECTION ONLY IF APPLICABLE

Personal Representative Signature: _____ Personal Representative Name (print): _____

Relationship to Patient, including the authority for status as Personal Representative: _____

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