Patient Authorization Form

I authorize Y-Access™ Support Solutions, a service of Verrica Pharmaceuticals, as well as CareMetx, insurance companies, my healthcare providers, specialty pharmacies, and any vendors contracted by such entities or the Y-Access Support Solutions program to use and share my Protected Health Information (PHI) with each other for specific purposes related to prescriptions for YCANTH™ (cantharidin) topical solution for the FDA-approved treatment of molluscum contagiosum to be administered by a healthcare professional.

I authorize the entities described above to receive, use, and disclose to one another my PHI in order to provide copay assistance, coordinate my benefits, provide reimbursement support, investigate my insurance coverage, help with financial assistance for YCANTH, provide patient and healthcare professional support services, ensure compliance with the requirements of the financial assistance services, and manage, administer, and/or support the Y-Access Support Solutions program and other business purposes. I understand that my PHI will not be used or disclosed for any other purpose without my prior authorization unless permitted by law or unless information that specifically identifies me is removed. The PHI to be shared may include my entire medical file, including but not limited to my demographic information, diagnosis and treatment information, prescription information, and financial information. I understand and acknowledge that my healthcare providers may receive remuneration for sharing my PHI if I sign this authorization.

I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by federal privacy law and may be subject to redisclosure. I understand that I am not required to sign this authorization as a condition of receiving treatment, payment, enrollment, or benefits from my healthcare providers.

I authorize Y-Access Support Solutions and the other entities described above to contact me to provide such services and information by mail, email, fax, telephone call, text message, and other means. I further understand that I do not have to agree to receive the services and communications described above and that I can still receive YCANTH, as prescribed by my physician. I understand that I am under no obligation to purchase YCANTH. I understand that if I receive copay assistance, I cannot seek reimbursement for YCANTH from any government insurance program and that any financial assistance cannot be counted toward my true out-of-pocket costs. I certify that I am at least eighteen (18) years of age.

I understand that I may revoke this authorization by notifying a program representative by telephone at 1-855-922-6847 or by sending a letter to 610 Crescent Executive Ct. Suite 200, Lake Mary, FL 32746, but that such revocation will not be effective with respect to actions already taken in reliance on this authorization. I understand that if I do not cancel this authorization, the authorization will expire 24 months from the date of signature (or the maximum period allowed by applicable state law, if less than 24 months).

I understand that I am entitled to receive a copy of this authorization once it has been signed.

By signing, I certify that I have read and agree to the above Patient Authorization.

Signature of patient, parent, legal guardian, or legal representative:

Name of signing party (please print):

Relationship to patient (if other than patient signing): Date:

Please see Important Safety Information and full Prescribing Information enclosed.