Purified Cortrophin™ Gel
repository corticotropin injection USP 80 U/mL

Consent to Receive Marketing and Other Text Messages

Once completed, please fax form to 1-833-302-1419

Patient Full Name

Date of Birth (mm/dd/yyyy)

Mobile Phone #

Address

Apt/Bldg/Fl

City

State

ZIP Code

Patient Telephone Consumer Protection Act Consent to Receive Additional Information from ANI Pharmaceuticals or *Cortrophin In Your Corner*™ Program

Marketing and Other Communications Opt-in:

By signing, I agree to receive marketing and other communications, including, but not limited to, transactional communications, offers, clinical trial opportunities, and educational materials and information related to my medical condition, treatment, and/or my prescription medication by autodialed SMS text messages and cell or other telephone calls. I understand that opting-in to receive these communications is not required as a condition of purchasing any goods or receiving a copay or other support from the program. Message and data rates may apply. Message frequency may vary. Reply STOP to cancel and HELP for help. By signing up to receive communications, you consent to receive disclosures electronically instead of in paper form. You can withdraw your consent to receive these disclosures at any time without penalty, and you can request a paper copy for no fee by calling us at 1-800-805-5258. You can also call us at that number to update your contact information. To ensure you receive and can retain the necessary disclosures, you must have a device (such as your mobile phone) with internet access, and either a printer or storage space to save the disclosures.

Failure to consent to receive marketing and other communications will not affect my ability to participate in the *Cortrophin In Your Corner* program. This authorization will remain in effect until I cancel it, which I may do at any time by calling ANI Pharmaceuticals at 1-800-434-1121 or *Cortrophin In Your Corner* at 1-800-805-5258 Monday-Friday, 8 AM-8 PM ET. I may request a copy of this signed authorization.

PATIENT NAME OR LEGAL REPRESENTATIVE

SIGNATURE

IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT

DATE

ani Pharmaceuticals, Inc.