CONSENT AND AUTHORIZATION

To Enroll in the Mito Assist™ Patient and Family Support Program

Mito Assist™ is a patient and family support program available at no cost for eligible patients prescribed FORZINITY™ (elamipretide) injection for subcutaneous administration. Sponsored by Stealth BioTherapeutics Inc., the maker of FORZINITY, Mito Assist offers support services for qualified patients related to insurance coverage and access for FORZINITY, patient support programs, support for at-home subcutaneous injection training, and education and resources.

MITO ASSIST PATIENT AND FAMILY SUPPORT PROGRAM OPT-IN FORM INSTRUCTIONS

A completed Patient Enrollment Form is required for a patient to enroll in Mito Assist. The Patient Enrollment Form can be found here https://anovorx.com/prescribers/. If you have any questions or concerns, please contact **1-833-458-9099**.

The patient/patient representative must sign and date the Patient Consent and Authorization to be enrolled in Mito Assist and gain access to support services and financial assistance programs, if eligible. See below to complete the Patient Consent and Authorization.*

*Note the Patient Consent and Authorization is section 9 of the Patient Enrollment Form. If you have already completed that section, you do not need to fill out the below.

PATIENT/PATIENT REPRESENTATIVE CONSENT AND AUTHORIZATION

Patient Consent and Authorization to Share Personal Information: By signing this Authorization, I hereby authorize my healthcare provider, including physicians and their staff, my health plan(s) providing medical care and prescription coverage, and any pharmacies providing FORZINITY™, to disclose my personally identifiable health and insurance information to Mito Assist™ operated by Stealth BioTherapeutics Inc. and their respective partners, affiliates, agents, and Mito Assist service providers (collectively, “Stealth”). This information includes but is not limited to my medical records, prescriptions, insurance coverage information, name, address, telephone number, and any additional information provided in this consent form and any prescription (my “Information”). I authorize Stealth to use my Information and to share it with my healthcare provider, including physicians and their staff, my health plan(s) providing medical care and prescription coverage, and my pharmacies providing FORZINITY.

I authorize Stealth to use and disclose my Information to (i) determine my eligibility for, facilitate my enrollment into, and administer the Mito Assist programs, (ii) ensure quality

and safety and improve Stealth's products and services, (iii) analyze the effectiveness of the patient support programs, including data analysis and compliance reviews, (iv) fulfill legal and regulatory requirements, and (v) conduct data analytics and other internal business activities.

Patient Support Services: I authorize Stealth to contact me by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voicemail).* I authorize Stealth to use my Information to provide support related to FORZINITY, including but not limited to verifying and navigating insurance coverage, providing financial assistance services, providing prescription fulfillment and delivery, administering and evaluating the effectiveness of the patient support program, and offering other support services and disease-related information. I understand that any personnel providing patient support services as part of Mito Assist are not employed by my healthcare provider(s) and may receive compensation from Stealth.

I understand that signing this Authorization is not required to receive medical treatment, health insurance benefits, or other healthcare services, but I will not be able to participate in Mito Assist patient support services without it. I may revoke this Authorization at any time by calling (833) 458-9099. Cancellation will end my consent to further disclosure of my health information to Stealth by my healthcare entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Authorization. Canceling this Authorization will not affect my ability to receive treatment, or my eligibility for health insurance. I have a right to receive a copy of this Authorization. This Authorization expires five (5) years from the date signed unless a shorter period is required by state law. I understand that the specialty pharmacy may receive payment from Stealth for providing patient support services and disclosing associated health information to Stealth pursuant to this Form. I understand that although Stealth has implemented privacy and security controls designed to help protect my Information, once my Information has been disclosed to Stealth, state and federal privacy laws, including the Health Insurance Portability and Affordability Act ("HIPAA"), may no longer apply and my Information may be subject to redisclosure. Stealth will not sell or trade my personal data to any unrelated third party. More information on Stealth's privacy practices, including specific rights I may have as a resident of certain states, can be found in Stealth's privacy policy at: https://stealthbt.com/privacy-policy/

*Data rates may apply.

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Opt-in for Other Resources: *optional*

☐ Yes, please, I would like Stealth to contact me regarding other potential topics of interest to me, customer surveys, opportunities to participate in marketing or disease awareness campaigns, or occasionally for market research purposes. I authorize such contact by mail, email, fax, text messaging, telephone (including calls and text messages made with an automatic telephone dialing system or a prerecorded voicemail).* I understand that I am not required to provide this consent as a condition for receiving any Stealth medicine or Mito Assist patient support services.

☐ No, thank you, I would like to opt out of receiving other resources

*Data rates may apply.

Terms, conditions, eligibility criteria, program maximums, and restrictions apply. Mito Assist is available only in the United States. Submission of an application or enrollment form does not guarantee participation, coverage, medication, or savings. Eligibility and assistance determinations are made on an individual, case-by-case basis and are subject to verification. Mito Assist does not provide medical or treatment advice and is not insurance and does not replace insurance coverage. No purchase is required for enrollment in Mito Assist; treatment decisions are made solely by patients and their healthcare providers. Programs are administered in accordance with applicable federal and state laws and may be changed, suspended, or cancelled at any time without notice.

*Form cannot be submitted unless signature included.

CONSENT AND AUTHORIZATION

Patient LAST Name * _____ Patient FIRST Name * _____ Patient's Date of Birth * _____

Legally Authorized Representative's Name (if required) _____ Legally Authorized Representative's Relationship to Patient _____

Patient's Legally Authorized Representative's Street Address * _____ City * _____ State * _____ Zip Code * _____

Patient's Legally Authorized Representative's Telephone/Home _____ Mobile * _____

Patient's Legally Authorized Representative's Email Address _____

Is there someone else with whom we may discuss your protected health information? * _____

Name _____ Relationship to you _____

Name _____ Relationship to you _____

Patient's Legally Authorized Representative's Signature

_____

*Form cannot be submitted unless signature included.