Sucraid (sacrosidase) Oral Solution Manufacturing Change
Patient Questionnaire - May be Completed by the Patient's Parent or Guardian

TO BE FILLED OUT AFTER TAKING SUCRAID FROM LOT NUMBER A1147 RELEASED DURING SUCRAID SHORTAGE

Patient name_____ **Phone number**_____

1. When did you first start taking Sucraid?
   Month: ____ Year: _____

2. Before you started taking Sucraid, what were your main symptoms? Circle all that apply.
   a) frequent diarrhea
   b) bloating
   c) excessive gassiness
   d) constipation
   e) abdominal cramps or abdominal pain
   f) weight loss
   g) other(s) _____

3. What is your age? _____ months old, OR _____ years old

4. When did you start taking Sucraid from this lot number A1147?
   Month: ____ Year: _____

Since you started taking the Sucraid lot number A1147 as indicated in #4:

5. Have you noticed any increase in your digestive symptoms (as indicated in #2) between previous lots and this lot of Sucraid?
   Circle one: Yes No

   If yes, what symptoms increased, and how many times each day did you have these symptoms?
   Symptom: _____ How many times each day _____
   Symptom: _____ How many times each day _____
   Symptom: _____ How many times each day _____

6. Have you experienced any side effects since taking this lot of Sucraid?
   Circle one: Yes No
   If so, please describe:
   _____

7. Have you noticed a change in the color of this lot of Sucraid?
   Circle one: Yes No
   If so, please describe:
   _____

8. What other changes have you noticed in this lot of Sucraid? Circle all that apply.
   a) Change in taste. Please describe_____
   b) Change in smell. Please describe_____
   c) Change in something else. Please specify and describe_____
   d) No change

9. Have you noticed any other significant symptoms that you believe are related to the new Sucraid? Please describe _____

HIPAA Statement

Authorization to Use and Disclose Protected Health Information ("Authorization"): I authorize my pharmacy, Accredo Health Group, Inc., QOL Medical, LLC, the maker of Sucraid®, dietary consultants, my physicians, and other healthcare providers, pharmacists, insurers, and any agent or representative of any of these parties (collectively, "Authorized Parties") to obtain the above and other individually identifiable health information ("IIHI") regarding me and my medical condition, symptoms, treatments, family medical history, insurance coverage and payment history, and diet, and to collect, use, and disclose my IIHI among each other and to/from third parties (which may include insurers, public funding programs, social workers, advocacy organizations, assistance organizations, healthcare providers, dietary consultants, and other persons or entities as any of the Authorized Parties may deem appropriate) to: (1) coordinate my treatment; (2) facilitate reimbursement support and obtain payment for my treatment; (3) provide me and my healthcare providers with free educational materials, dietary support, and/or peer consultation; (4) conduct healthcare marketing activities, including those for which an Authorized Party may receive compensation; and (5) carry out any other purpose required or permitted by law. I understand that any of the Authorized Parties may need to contact me for additional information. For purposes of this authorization, I understand that my IIHI includes any individually identifiable information about me such as my social security number, contact information, medical condition or other health information, and treatment and payment history relating to my past, present, and future use of Sucraid® and other healthcare items or services. I understand that once my information is disclosed under this authorization, it may be further disclosed and no longer protected by federal confidentiality laws. I understand that treatment by my physician and payment, enrollment, or eligibility to receive Sucraid® is not conditioned upon the signing of this authorization. However, if I refuse to sign this authorization, my ability to receive support services related to my use of Sucraid® may be limited. I understand that this authorization will remain in effect until the later of ten (10) years from the date of my signature or five (5) years following my discontinuance of purchase of Sucraid® from Accredo unless I revoke it by sending written notice to the Sucraid® Program Manager at Accredo Health Group, Inc., 1640 Century Center Pkwy., Memphis, TN 38134. If I revoke this authorization, Accredo will communicate my revocation to the Authorized Parties and will stop using and disclosing my information as soon as possible. However, my revocation will not affect any prior use or disclosure of IIHI made in reliance on this authorization and my revocation will not affect my treatment by my physician. If I have questions about disclosures of my IIHI, I may contact the Privacy Officer at Accredo Health Group, Inc. at privacy@express-scripts.com. I understand that I have the right to receive a copy of this authorization. I further understand that I have the right at any time to refuse dietary support or peer consultation.

Patient Name (please print) _____ Date_____

Patient Signature (or representative) _____ Relation to patient _____

When you have completed the questionnaire, please send the completed questionnaire by mail (using the postage paid envelope) or by email to info@sucraid.net.

Postage paid envelope to:

QOL Medical, LLC
2015 Patient Questionnaire
3405 Ocean Drive
Vero Beach, Florida 32963

Email to: info@sucraid.net

If you have any questions about this questionnaire, you may call Brandi Rabon, QOL Medical Patient Advocate at 704-692-1634 or brabon@qolmed.com.

Thank you for your time and assistance.