UNCOVERING RARE OBESITY™

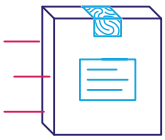
Consent form instructions for Canadian participants

PREVENTION GENETICS
part of EXACT SCIENCES

COMPLETE YOUR CONSENT FORMS IN 3 EASY STEPS

1 | Review the forms on pages 2-4.

2 | **REQUIRED Consent:** Complete, sign, and date the form on pages 2-3.
OPTIONAL Authorization: If you agree, complete sign, date the form on page 4.



3 | Include your completed forms in the box with your genetic test sample.

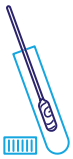
RHYTHM IS COMMITTED TO ADVANCING THE UNDERSTANDING OF RARE GENETIC DISEASES OF OBESITY

At Rhythm, we believe it's important to take your privacy very seriously. That is why we:

- Ask for your consent to collect or share your de-identified information
- Give you the choice to decide whether your identifiable information may be shared with us

Your consent is requested in two areas.

The first form gives your permission to conduct the genetic test and is **REQUIRED** for participation in the program. The second form is **OPTIONAL** and allows the lab to share your identifiable information with Rhythm to facilitate contacting you and your doctor about research opportunities.



Section 1 | **REQUIRED consent for genetic testing and participation**

This consent is **REQUIRED** in order to participate in the URO program and gives your permission for an independent certified laboratory, PreventionGenetics, to analyze your (or your child's) genetic information through the test sample provided. The lab may share your results with Rhythm Pharmaceuticals for the purposes of carrying out the program and advancing research efforts. However, before doing so, it will remove your personally identifying information (called de-identifying), so that Rhythm Pharmaceuticals does not receive test results with your identifiable information (or your child's).

Section 2 | **OPTIONAL* authorization to use and disclose identifiable information**

With this **OPTIONAL** authorization, you allow the laboratory to share your Identifiable Health Information with Rhythm Pharmaceuticals to facilitate Rhythm's sharing of information about research opportunities with you and your doctor.

*This authorization is completely voluntary/optional.

UNCOVERING RARE OBESITY™

Section 1: Consent for genetic testing and participation in sponsored testing program in Canada

PREVENTION GENETICS part of EXACT SCIENCES

Rhythm Pharmaceuticals, Inc. ("Rhythm") is providing the Uncovering Rare Obesity Gene Panel ("the Genetic Test") under a sponsored genetic testing program ("the Program") to healthcare providers and their patients to help identify rare genetic diseases of obesity. Rare genetic diseases of obesity are associated with early-onset, severe obesity that may be accompanied by insatiable hunger. The Genetic Test will be performed by PreventionGenetics, LLC ("PG") in a clinical DNA testing laboratory accredited in the USA under the *Clinical Laboratory Improvement Amendments*. Under the Program, the Genetic Test will be provided at no charge to patients, excluding the cost of office visits, sample collection, and any other related costs, which shall be the patient's responsibility.

I UNDERSTAND AND AGREE THAT:

1 | The purpose of the Genetic Test, which will be conducted by PG and is sponsored by Rhythm, is to identify gene variants that may cause or predispose an individual to rare genetic diseases of obesity. This test analyzes the sequence of specific genes for variants that may cause or predispose an individual to rare genetic diseases of obesity. No other tests other than those authorized in this Consent Form shall be performed on saliva or buccal samples provided.

2 | My/my child's healthcare provider has advised me that he/she would like to order the Genetic Test and has confirmed that I/my child meets one of the eligibility criteria below:

- Age of ≥19 years of age, BMI ≥40, and a history of childhood obesity
- Age of ≤18 years of age, BMI ≥97th percentile
- Family testing for previously reported Uncovering Rare Obesity Gene Panel positive findings
- Suspected or clinical diagnosis of Bardet-Biedl syndrome
- Other clinical justification to support exemption from eligibility criteria; approved by Rhythm

3 | The Genetic Test provided under the Program requires that I/my child provide a saliva or buccal specimen for testing, which will be conducted by PG. My healthcare provider has explained the risks (if applicable), and I consent to the specimen being collected and shared with, and analyzed by, PG's employees and agents on a need-to-know basis and under a duty of confidentiality. This information may be disclosed to its service providers working on PG's behalf for technical reasons and, to Rhythm, as the sponsor, under the conditions provided by section 7. Such information will only be kept for the time necessary to such purpose, for a duration not exceeding the applicable legal limitation periods, and will be stored in the United States with appropriate physical, organizational, contractual, and technological security measures.

4 | My healthcare provider has also discussed the following with me:

- The Genetic Test will include gene variants that may cause or predispose an individual to certain rare genetic diseases of obesity
- The limitations of genetic testing: Some genetic test results may not necessarily be conclusive in all individuals for purposes of establishing a diagnosis of a rare genetic disease of obesity
- The meaning of a negative genetic test result (where nothing is reported back to me from the test) and what the negative result may mean for me/my child, along with the limitations of negative results
- The meaning of a positive result: As the Genetic Test looks for a variant associated with a rare genetic disease of obesity, the likelihood of a positive result in any individual patient may be low. I may consult with my healthcare provider or ask to be referred to a geneticist, genetic counselor, or other qualified healthcare provider to discuss any additional testing or counseling that may be helpful. I understand that I would be responsible for the costs associated with such counseling, except where I use the no-charge genetic counseling offered under the Program
- Learning about test results may be stressful and upsetting for me and my family
- It is my responsibility to consider the possible impact of my/my child's test results as they relate to insurance rates, obtaining disability or life insurance, and employment. I may consult with other professionals or genetic counselors who are experts in this area to counsel me

(continued on next page)

- Errors or incorrect results may occur; however, control measures are in place to limit them to the extent possible. Sources of error may include, but are not limited to: specimen contamination, technical laboratory mistakes, presence of DNA variants that compromise data analysis, inconsistent scientific classification systems, and inaccurate reporting of family relationships or clinical diagnosis information
- Reports are current as of the date provided. However, as genetic knowledge and understanding increases and evolves, it is possible that the clinical significance of the genetic variant(s) identified in my/my child's sample will change over time. To the extent such additional interpretive information is provided at PG's and Rhythm's sole discretion, I should discuss with my/my child's healthcare provider

5 | The results of the Genetic Test in the form of a clinical report will be released to the healthcare provider(s) listed on the test requisition form. My/my child's healthcare provider may communicate with me about possible eligibility for future clinical trials or other research opportunities based on my/my child's Genetic Test results.

6 | I/my child may be offered no-charge genetic counseling with a genetic counselor who can answer questions and provide information and advice about testing before and after having the Genetic Test. I authorize PG to release a copy of my/my child's Genetic Test results to the genetic counseling provider under the Program.

7 | PG may disclose my Genetic Test results after stripping them of directly identifying information ("De-identified Results") to Rhythm for the purposes of carrying out the Program, including potentially contacting my healthcare provider to discuss treatment options or to discuss possible eligibility for clinical trials or other research opportunities. Rhythm may store De-identified Results in the United States, for the time necessary for such purpose or such longer period as may be permitted or required by applicable law. Rhythm may also use and disclose De-identified Results for its business purposes, research, and publication, and to conduct other analyses. My/my child's name or other personal identifying information will not be used in or connected to the results in any educational materials, presentations, or other publications. Rhythm will take steps to protect my De-identified Results from use or disclosure in a manner not permitted under applicable laws and regulations.

8 | The use of my/my child's De-identified Results may lead to commercial products in the future. Neither I nor my child will receive compensation or any rights or interests in those products.

9 | If I do not sign this form, I understand this means I will not be able to participate in the Program.

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

I, the undersigned, have reviewed the information referenced above, including information regarding the possible benefits and risks of the Genetic Test. I have reviewed this informed consent. I have been given the opportunity to ask questions before I sign this document, and I have been told that I can ask additional questions at any time. Finally, I understand that I can revoke consent at any time (revocation of consent would not affect the use or disclosure of any De-Identified Results already generated) and that I have a right to access and to rectify my information under conditions. To revoke consent, I can contact **PreventionGenetics at 1-715-387-0484 or submit a written request to:** PreventionGenetics, LLC, 3800 South Business Park Avenue, Marshfield, WI 54449. I may also contact privacy@rhythmtx.com.

I consent to the Genetic Test and participation in the Program as described in this Consent Form and request and permit PG to analyze MY/MY CHILD'S genetic information in the sample provided to PG in connection with the Program as described in this Consent Form.

SIGN HERE >

PATIENT SIGNATURE	PATIENT NAME (PLEASE PRINT)	DATE
PARENT / GUARDIAN SIGNATURE, IF PATIENT IS A MINOR	PARENT / GUARDIAN NAME (PLEASE PRINT)	DATE

UNCOVERING RARE OBESITY™

Section 2: Optional authorization to use and disclose Identifiable Health Information

PREVENTION GENETICS part of EXACT SCIENCES

Note: Not providing authorization in this section does not preclude participation in the URO program.
Rhythm Pharmaceuticals, Inc. ("Rhythm") is providing the Uncovering Rare Obesity Gene Panel ("the Genetic Test") under a sponsored genetic testing program ("the Program") to healthcare providers and their patients to help identify rare genetic diseases of obesity. Rare genetic diseases of obesity are associated with early-onset, severe obesity that may be accompanied by insatiable hunger. The Genetic Test will be performed by PreventionGenetics, LLC ("PG") in a clinical DNA testing laboratory accredited in the USA under the *Clinical Laboratory Improvement Amendments*.

IF I CHOOSE TO SIGN THIS AUTHORIZATION, I UNDERSTAND AND AGREE THAT:

1. Rather than disclose to Rhythm only my Genetic Test results that have been stripped of personal identifying information as described in the Consent for Genetic Testing and Participation in Sponsored Testing Program, PG may use and disclose to Rhythm and others working for or with Rhythm, on a need-to-know basis and under a duty of confidentiality, my identifiable Genetic Test results, my contact information, and other clinical information provided by my doctor on the form to request Genetic Testing (collectively, "**Identifiable Health Information**").
2. The purposes for PG's use and disclosure of my Identifiable Health Information to Rhythm is to enable Rhythm to help determine my eligibility for clinical trials and other research studies that are conducted on behalf of Rhythm or other entities, including research about my experience with this Sponsored Testing Program, and to contact me about potential research opportunities for which I may be eligible. I am under no obligation to participate in any of the research opportunities that I may be contacted about.
3. This authorization will remain in effect for five years from the date of my signature below unless a shorter period is provided for by applicable law, after which my Identifiable Health Information will be deleted or anonymized.
4. My Identifiable Health Information is stored in the United States, and physical, organizational, contractual, and technological security measures have been put in place to protect it.
5. This authorization is voluntary, and I am not required to sign this authorization. PG cannot condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
6. I may revoke (take back) this authorization at any time in writing by sending a letter to PG at the address listed below. If I revoke my authorization, it will not affect uses and disclosures of my Identifiable Health Information that were already made before PG received my authorization revocation. In addition, PG will not be able to take back my Identifiable Health Information that it has already shared with Rhythm before it received my authorization revocation. If I revoke my authorization, PG may still use the Identifiable Health Information for certain purposes, such as to comply with the law. Finally, I understand that I can revoke consent at any time and I understand that applicable law may provide me with a right to access and to rectify my Identifiable Health Information, whether held by PG or by Rhythm under conditions.

To revoke this authorization, to change your contact information, or to exercise your rights of access and/or rectification, please call PreventionGenetics at 1-715-387-0484 or submit a written request to: PreventionGenetics, LLC, 3800 South Business Park Avenue, Marshfield, WI 54449.

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

I, the undersigned, have read and understand this authorization. I authorize the use and disclosure of my Identifiable Health Information as described above.

SIGN HERE >

PATIENT SIGNATURE	PATIENT NAME (PLEASE PRINT)	DATE
PARENT / GUARDIAN SIGNATURE, IF PATIENT IS A MINOR	PARENT / GUARDIAN NAME (PLEASE PRINT)	DATE