Pr Envarsus® PA
(tacrolimus prolonged-release tablets)

PrENVARSUS® PA Patient Support Program
Toll free phone: 1-877-261-4586 • Toll free fax: 1-833-377-0556 • Email: envarsus@bayshore.ca
This enrollment form serves as your prescription for PrENVARSUS® PA (Tacrolimus prolonged-release tablets).

Please send this form to the PrENVARSUS® PA Patient Support Program by **Fax to 1-833-377-0556 or by Email to envarsus@bayshore.ca**

PATIENT INFORMATION

First Name | MI | Last Name | DOB (dd/mmm/yyyy) | Gender : M ☐ F ☐

Address | City | Province/Territory | Postal Code

( ) Home Phone | ( ) Cell Phone | ( ) Work Phone | Email

Best time to call Morning ☐ Afternoon ☐ Evening ☐ Messages may be left Home ☐ Cell ☐ Text/SMS ☐

Primary Contact | Relationship to patient | Health Card Number

PRESCRIBER INFORMATION

First Name | Last Name | License Number | Clinical Institution

Address | City | Province/Territory | Postal Code

( ) Phone | ( ) Fax | Email

PRESCRIPTION

PrENVARSUS® PA supplied as 0.75 mg (DIN: 02485877), 1mg (DIN: 02485885), 4mg (DIN: 02485893) tablets

I verify that the patient named above meets the indication and clinical use as described in the Health Canada approved Product Monograph for PrENVARSUS® PA Yes ☐ No ☐

Indication: _____

Dose: _____mg Repeat: _____

Special Instructions: _____

PATIENT AUTHORIZATION

Patient/Legal Representative Signature

Name of Legal Representative

Relationship to Patient

Date (dd/mmm/yyyy)

PHYSICIAN AUTHORIZATION

Physician Signature

Date (dd/mmm/yyyy)

I certify that this constitutes an original prescription for PrENVARSUS® PA and authorize the Program to provide Patient Reimbursement Support services and other services on the reverse.

By signing this form I agree to have read and understood the Terms and Conditions on the reverse side

Physician terms and conditions

I, the prescribing physician for the patient identified on this form, understand the Services (as defined below) offered by the PrENVARSUS® PA Patient Support Program herein referred to as "the Program".

I represent that: (i) I have met with the patient and discussed the Program with him/her; (ii) the patient understands the Program; (iii) the patient is interested in enrolling in the Program; (iv) the patient has consented to me filling out the form which includes adding personal information of the patient, and communicating it to the Program Administrator (as defined below) for purposes of enrollment in the Program; and (v) the patient agrees to be contacted by the Program Administrator to initiate his/her enrollment in the Program. I certify that my patient's condition is within the indications listed in the current PrENVARSUS® PA product monograph and that the dosage is appropriate based on my clinical judgement.

I understand that I will not receive any payment from the Program for the navigation of reimbursements. I may be contacted by the Program Administrator for the purpose of sharing relevant information related to Services provided to the patient. I hereby consent to the collection of personal information by the program, its use to facilitate the functions and activities of the program, and the disclosure of information to the Program Administrator for the purpose of regulatory adverse event reporting requirements, program monitoring and evaluation, and the collection, use and disclosure of the information as permitted or required by Law. My signature acknowledges that I am the treating physician of this patient and I also consent to be contacted by the Program Administrator for the purpose of inquiring about my experience with the Program so that services may be improved.

I understand that I may revoke this consent at any time by mailing or faxing a signed request to the Program Administrator (see below). I consent to the use and transfer of my name, license number, and coordinates to the appropriate payors to assist with obtaining public or private coverage for PrENVARSUS® PA for my patient, where applicable. I also agree to the disclosure of appropriate clinical documentation to controllers and auditors contracted by Paladin (the Canadian license holder of PrENVARSUS® PA) for audit purposes.

I agree to the disclosure of my license number and contact information to Paladin for reporting purposes including but not limited to research and development, and sales data. I understand that Paladin reserves the right to terminate, modify, and/or transfer the Program to a third-party including by appointing a new Program Administrator at any time for any reason.

Patient terms and conditions

I understand that the objectives and purposes of the PrENVARSUS® PA Patient Support Program, herein referred to as "the Program," consist of offering confidential patient-support services, free of charge, designed for patients who have been prescribed PrENVARSUS® PA. I will be offered, depending on my eligibility or need: case management, reimbursement assistance, financial assistance and pharmacy services. I have been given the opportunity to discuss the Program with my healthcare provider (e.g. doctor or nurse) and I understand that participation in the Program is voluntary. I agree and give my consent, to my healthcare provider and my health insurer to provide details of my personal information (which may include my name, address, email address and phone number, financial information as well as sensitive personal health information including my medical history, my medical condition and other health information, health insurance information as well as all information included on this form) to the Program Administrator (as defined below), for the purpose of determining my eligibility for participation in the Program or for purposes of providing Services. I also authorize my healthcare provider to provide the Program Administrator with this completed form.

I understand the Program Administrator is responsible for the collection, use and disclosure of my personal information collected for the purposes of administering the Program, as described in this form. I understand that Paladin (the Canadian license holder of PrENVARSUS® PA) may receive aggregate and/or anonymized data in respect to the Program, but will not receive information that could identify me, except, if required, in the following special circumstances: (i) if a complaint form is filled out by me or my healthcare provider; (ii) if my healthcare provider has a special request that would require pre-authorization from Paladin; (iii) if my healthcare provider receives special instructions on an enrollment form that would require Paladin's involvement in coordinating the request; or (iv) in the case of an adverse event, as required by regulations, to enable Paladin to follow up with my healthcare provider and comply with its regulatory obligations.

I understand that the file(s) containing my personal information will be maintained by the Program Administrator. I understand that the Program Administrator will collect, use, disclose and protect my personal information as described in this form and in accordance with its privacy policy available at https://www.bayshore.ca/privacy-policy/.

I further understand that authorized employees, agents representatives as well as any third party contracted by Paladin or the Program Administrator to provide services will have access to my personal information to the extent necessary to administer the Program and provide Services to me. I understand that my personal information will not be used by the Program Administrator for any purpose other than the administration of the Program and provision of Services to me. I understand that my personal information may be collected, used and disclosed and/or stored outside of my province/territory or country, and the privacy laws of those jurisdictions may be less stringent than the laws of Canada and/or my home province/territory.

I understand that I may request access to, or correction of, my personal information, as well as any other information or support in relation to the Program by contacting the Program Administrator (see below). I hereby consent to the collection, use, disclosure and/or storage of my personal health information by the Program Administrator for the purpose of providing services, monitoring the program, reporting adverse events in accordance with its privacy policies. I authorize Program Administrator to contact as well as collect further information from my prescribing/treating physician and/or Health Care Provider as necessary. I understand that I may revoke my consent to participate in the Program at any time by mailing or faxing a signed request to the Program Administrator however, I understand that if I withdraw my consent, such withdrawal will have no retroactive effect (it will be effective as of the date of receipt of my withdrawal notice). I also understand that if I withdraw my consent I will not be able to receive Services. Any personal information already provided will be retained by the Program Administrator for purposes of documenting the management of Services already provided until such information is no longer required for such purposes. Withdrawing my consent will result in the termination of my enrollment in the Program.

I understand that any financial assistance provided as a result of my enrollment in the Program may be reportable income to public or private payers or government agencies and that I am solely responsible for such reporting as well as for ensuring compliance with accepting any such financial assistance. The Program Administrator is Bayshore HealthCare and can be contacted in writing at 2101 Hadwen Road, Mississauga, Ontario, L5K 2L3 fax 1-833-271-1790, phone 1-877-318-4462 or email envarsus@bayshore.ca Paladin reserves the right to change the Program Administrator on written notice to me and I consent to my information being transferred to any new Program Administrator for the purposes of administering the Program. I understand that Paladin reserves the right to terminate, modify and/or transfer the Program to a third-party (including by appointing a new Program Administrator) at any time for any reason.

I have read the above Program terms and conditions herein referred to as "Terms and Conditions", and I agree to the collection, use and disclosure of my personal information, including my sensitive personal health information, in accordance with these Terms and Conditions. I understand the Services offered by the Program as well as my rights set forth in the Terms and Conditions and I am aware that I am entitled to a copy of this document. I understand that if I have any questions I can contact the Program Administrator before signing this form.

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