KabiCare
Patient support program from Fresenius Kabi

t: 1 (888) 304-2034 e: info@kabicare.ca

PrIDACIO® (adalimumab) Enrolment Form

Fax the completed form to 1 (888) 304-2014

Patient Information

Patient Name: _____

Sex: ☐ Male ☐ Female ☐ Other: _____

Date of Birth (dd/mm/yyyy): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Diagnosis: _____

Adalimumab History: ☐ Naïve ☐ Switch

Email: _____

Best Contact #: _____ Message OK ☐ Y ☐ N

Alt. Contact #: _____ Message OK ☐ Y ☐ N

Pref. Language: ☐ EN ☐ FR ☐ Other: _____

Medical Work-Up – PSP to Coordinate

☐ Chest X Ray	☐ TB Skin	☐ TB QuantiFERON
☐ Other: _____		

Assessment Details (please complete if necessary)

Psoriasis

BSA%:	PASI:	DLQI:

☐ Face ☐ Hands ☐ Feet ☐ Genitals ☐ Other

Hidradenitis Suppurativa

Location(s):	Hurley Stage:	Total Abscess and Inflammatory Nodule (AN) Count:

Previous Therapy

Psoriasis

	Reason for Discontinuation	Duration
☐ Methotrexate		
☐ Acitretin		
☐ Cyclosporine		
☐ Topicals		
☐ Other: _____		
☐ Phototherapy**		

Hidradenitis Suppurativa

	Reason for Discontinuation	Duration
☐ Antibiotics‡		

** For patients with chronic moderate plaque psoriasis, Idacio® should be used after phototherapy has been shown to be ineffective or inappropriate.
‡ Antibiotics may be continued during treatment with Idacio® if necessary.

Prescriber Information

Prescriber Name: _____

License #: _____

Clinic Name: _____

Clinic Primary Contact: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Fax: _____

Prescription Information - ℞ Select a Diagnosis, Dosage and Duration:

☐ **Adult Plaque Psoriasis (PsO)**

☐ **Adolescent Hidradenitis Suppurativa (HS) 12-17 years of age weighing ≥30 kg**

☐ Week 0 = IDACIO® 80 mg* (SC) and then 40 mg every other week, beginning Week 1 (SC)

☐ **Adult Hidradenitis Suppurativa (HS)**

☐ Week 0 = IDACIO® 160 mg† (SC); Week 2 = IDACIO® 80 mg* (SC) and then 40 mg every week, beginning Week 4 (SC)

* Given as 2 x 40 mg injections in one day; † Can be given in 1 day (4 x 40 mg injections) or split over 2 consecutive days (2 x 40 mg injections/day)

IDACIO® — Other dosing (specify):

_____

Duration: ☐ 3 months ☐ 6 months ☐ 12 months

☐ Other: _____

Format: ☒ Autoinjector

I hereby acknowledge that I am the patient's attending physician and that the patient is ready to start therapy. I authorize KabiCare to be my designated agent to forward this prescription by fax, or other mode of delivery, to the pharmacy chosen by the above named. This prescription represents the original prescription drug order. The patient's chosen pharmacy is the only intended recipient and there are no others.

Signature: _____ Date (dd/mm/yyyy): _____

☐ Pre-biologic workup pending

☐ Patient ready to begin therapy ☐ Patient requires injection training

Other notes: _____

Patient Consent

I have read this form, including the Consent, or it has been read to me. I agree to be enroled in the KabiCare Patient Support Program and authorize the use and disclosure of my information as described in this form.

Signed by: ☐ Patient ☐ Legal Representative

Signature: _____

Name of Legal Representative: _____

Date (dd/mm/yyyy): _____

Relationship to Patient: _____

IMPORTANT: If unable to obtain written consent from patient/legal representative please document when verbal consent was obtained and by whom. This will allow the KabiCare Patient Support Program to continue with processing this enrolment.

Verbal Consent Obtained from:

☐ Patient ☐ Legal Representative

Name of Legal Representative: _____

Verbal Consent Obtained by: _____

Relationship to Patient: _____

Signature: _____

Date: (dd/mm/yyyy): _____

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Patient Enrolment Form Terms & Conditions of the Program

We respect your right to privacy.

Please read and agree to these terms ("Agreement") in order to enrol in the KabiCare Patient Support Program (the "Program").

I have been prescribed IDACIO® (adalimumab) and wish to enrol in the Program provided by Fresenius Kabi ("FK") and which is currently administered on FK's behalf by Sentrex Health Solutions (the "Administrator"). **I understand and agree to the following**:

- Participation in the Program is not required to access IDACIO® treatment. As participation in the Program is entirely voluntary, I may grant or withhold my consent to the collection, use and disclosure of my Personal Information, as described below, in my sole discretion.
- By signing below, I consent to the terms and conditions of this Agreement, and I understand that:
    - I am entitled to a copy of this Agreement;
    - References to the "Program" and "Program Personnel" in this Agreement include FK, the Administrator, and their respective personnel who are involved in the design, administration and implementation of the Program. Accordingly, certain identifiable information about me, including my Personal Health Information ("Personal Information") will be collected, used and disclosed by the Administrator and/or FK as described below, and such Personal Information may be shared by the Administrator with FK and vice versa.
- The Program will involve collection of the following Personal Information about me:
    - My contact information – i.e., Name, address, email, phone number; My demographic information - i.e., Date of birth, gender; My financial information; and My medical history, treatment plans, lab results, insurance coverage, benefit plan ID number, governmental health care number ("Personal Health Information").
- My Personal Information will be used for the purposes of enroling me in the Program, communicating with me, administering the Program, providing the Services, and complying with legal requirements (collectively, the "Permitted Purposes"). I understand that references to "Services" herein mean the services offered by the Program, including without limitation, reimbursement and financial navigation assistance, education, training and pharmacy coordination services.
- My Personal Information will not be used by FK or the Administrator for any other purpose, unless I provide my consent or such use is required by applicable laws or permitted without my consent pursuant to applicable privacy legislation.
- My Personal Information will be stored electronically in Ontario, Canada.
- My physician and other healthcare professionals and/or health insurer(s) ("Healthcare Providers") may disclose my Personal Information to FK and/or the Administrator, and I consent to FK and/or the Administrator collecting my Personal Information from such third parties for the Permitted Purposes.
- My Personal Information will be disclosed by FK and/or the Administrator to the following:
    - My Healthcare Providers, for the Permitted Purposes and to provide healthcare to me; The Program's service providers and affiliates, which will only use such information for the Permitted Purposes; or Other third parties, with my consent, or if permitted or required by applicable law, including without my knowledge or consent (e.g., for the purposes of fraud prevention or in the context of a sale of business or pursuant to a court order or regulatory demand, or to health authorities as described below).
- My Personal Information may be combined with the information of others to generate aggregated anonymized data. This data may be used by FK, the Administrator, and/or their service providers to monitor, improve, and refine the Program, to design and implement other patient programs, and for the purposes of research, publications, education.
- FK has a legal obligation to report adverse drug events to Health Canada and international health authorities and to monitor product complaints. Personal Information provided to the Program may be (i) monitored by FK or its service providers for safety related data and product complaints, and (ii) reported to local or international health authorities. FK may contact me or my Healthcare Providers for additional information to fulfill its reporting obligations.
- The Program may contact me by any means (e.g. phone, text, email, mail, fax, etc.) for the purposes of administering or improving the Program (including sending surveys), and providing the Services.
- FK may transfer my Personal Information to a third party in connection with the sale or transfer of all or a portion of its business or assets. I understand that the transferee will only collect, use and disclose such Personal Information in a manner that is consistent with this Agreement;
- I may withdraw or revoke my consent at any time by mailing, emailing or faxing a signed request to the Administrator, but if I do so I understand that to the extent that such consent is necessary to provide the Services under the Program, my participation in the Program and access to the Services, including reimbursement and copay assistance, may be terminated. I understand that withdrawing my consent does not exclude me from receiving IDACIO® treatment. If I withdraw consent the Program may retain Personal Information to comply with legal requirements.
- My Personal Information may be collected, accessed, used, disclosed, transmitted and/or stored outside of my province or outside Canada. I understand that information transferred or stored outside Canada may be accessible to foreign courts, law enforcement and regulatory authorities.
- I am aware of the reasons why my Personal Health Information is required in connection with the Program, as well as the risks and benefits to me of consenting or refusing to consent to the collection, use and disclosure of my Personal Health Information as described in this Agreement.
- I may access, examine and/or request a copy of my Personal Information, update such Personal Information, correct any errors in my Personal Information, and/or direct questions regarding the collection, use and disclosure of my Personal Information by contacting the Administrator. I may also contact the Administrator in order to obtain access to written information about FK's and/or the Administrator's policies and practices with respect to collection, use, disclosure and storage of Personal Information by the Program's service providers and affiliates outside Canada.
- Any financial assistance provided to me through the Program may be reportable income to public or private payors or government agencies, and I am solely responsible for any such reporting as well as ensuring compliance with accepting such financial assistance.
- My Personal Information will be retained by FK and the Administrator only for as long as is needed to fulfill the purposes for which it was collected and in order to comply with applicable laws.
- My Personal Information can only be collected, used and disclosed without my consent as permitted or required by applicable laws, and in particular, that my Personal Health Information can only be collected, used or disclosed without my consent in accordance with applicable health privacy legislation.
- The Administrator, Sentrex Health Solutions, is located at 3–250 Shields Court, Markham, ON, Canada, L3R 9W7. I may contact the Administrator to withdraw or revoke my consent, or to ask any questions, by phone 1-888-304-2034], email info@kabicare.ca, or by fax at 1-888-304-2014. FK may change the Administrator upon written notice to me and I consent to my Personal Information being transferred to any new Administrator for the Permitted Purposes. In such case, FK will send a notice with contact information for the new Administrator to the address or email address that I have provided to the Program.
- FK may terminate or modify the Program, or certain eligibility requirements, at any time and without advance notice. Further, FK may amend this Agreement at any time to address changes to applicable laws, company policies or business practices. In the event of any material changes, I will be notified in writing prior to such changes taking effect.

REVIEWED BY PAAB

FRESENIUS KABI