Enliven® PATIENT SUPPORT PROGRAM — Enrolment form

Enrol in the En*liven*® Patient Support Program
1-833-423-0252 1-877-936-2735

AMGEVITA® adalimumab injection

Patient information

First name _____ Last name _____

Date of birth (dd/mm/yyyy) _____ ☐ Female ☐ Male

Do you have health insurance coverage? ☐ Private ☐ Public ☐ Both

Contact information

Preferred phone _____ Alternate phone _____

Preferred time to call ☐ Morning ☐ Afternoon ☐ Evening

Preferred language _____ Email (optional) _____

Address _____ City _____

Province _____ Postal code _____

By providing my email address, I agree that representatives of McKesson Canada Corporation ("**McKesson**"), acting on behalf of Amgen Canada Inc. ("**Amgen**"), may communicate with me via electronic means such as email and text message, for the purposes of providing me with information and updates relating to my enrolment in the En*liven*® Patient Support Program (the "**Program**"). I understand that communicating via electronic means may not be the most secure means of communication and while efforts are made not to include sensitive health information in any electronic communication, such communications may identify me as a registrant with the Program. At any time, I will have the opportunity to opt out from such electronic communications by providing notice to McKesson at 901 King St. West, Suite 300, Toronto, Ontario M5V 3H5, by calling 1-877-936-2735, or by sending an email to amgevita@oneenliven.ca.

I have read and understood the patient consent information on the second part of this enrolment form and agree to the collection, use, and disclosure of my personal information in accordance with these terms.

By checking the boxes below and providing my signature, I confirm I have read, understood, and agreed to the following consent information on the second part of this enrolment form:

☐ The terms about sharing information about all my enrolments under the En*liven*® program, as applicable, **if I am enrolled under the En*liven*® program for more than one medication**.

☐ The terms **about being contacted for surveys/marketing purposes**.

☞ _____ Date (dd/mm/yyyy) _____

Patient signature

☐ I, the prescribing physician/healthcare provider, attest that the named patient has provided their express verbal consent to initiate enrolment in the Program and share their information for the purposes set out herein.

Prescribing physician section
Please ✓ and complete the required information

Physician information

Physician name _____

Phone _____ Fax _____

Email _____

Preferred form of contact ☐ Phone ☐ Fax ☐ Email

Other information/office stamp

Prescription information
℞

Treatment context

☐ **Patient already on adalimumab** ☐ **Patient new to adalimumab**

Diagnosis and dosage

☐ **Rheumatoid arthritis (RA)**
☐ **Psoriatic arthritis (PsA)**
☐ **Ankylosing spondylitis (AS)**
☐ 40 mg every other week

☐ **Adult Crohn's disease (CD)**
☐ **Ulcerative colitis (UC)**
☐ Week 0=160 mg; Week 2= 80 mg; then 40 mg every other week beginning Week 4

☐ **Plaque psoriasis (PsO)**
☐ **Uveitis**
☐ **Adolescent hidradenitis suppurativa (HS)** (12–17 years of age weighing ≥ 30 kg)
☐ Week 0=80 mg; then 40 mg every other week beginning Week 1

☐ **Pediatric Crohn's disease (CD)**
☐ Week 0=160 mg; Week 2=80 mg; then 20 mg every other week beginning Week 4

☐ **Hidradenitis suppurativa (HS)**
☐ Week 0=160 mg; Week 2=80 mg; then 40 mg weekly beginning Week 4

☐ **Pediatric uveitis** (≥ 2 years of age; in combination with methotrexate)

☐ **Polyarticular juvenile idiopathic arthritis (JIA)** (≥ 2 years of age)
☐ Patient weight 10 kg to < 30 kg: 20 mg every other week
☐ Patient weight ≥ 30 kg: 40 mg every other week

Other dose (mg) / Frequency

_____
_____
_____
_____
_____

Format

AMGEVITA® is available in a 40 mg single-use prefilled SureClick® autoinjector and in 20 mg and 40 mg single-use pre-filled syringes, supplied in boxes of two units.

☐ SureClick®
☐ Prefilled syringe

Duration of treatment

☐ **12 months** ☐ **6 months** ☐ **3 months** ☐ **Other** _____

Injection training

I would like En*liven*® to provide injection training. ☐ Yes ☐ No

Provincial formulary code (if applicable) _____

Medical information – Official prescription information

Chest X-ray
☐ Completed ☐ Not complete
☐ Not required

Date completed (dd/mm/yyyy) _____

Result _____

TB test
☐ Completed ☐ Not complete
☐ Not required

Date completed (dd/mm/yyyy) _____

Result _____

Patient to start AMGEVITA® ☐ Immediately **OR** ☐ Pending test results

☐ BY CHECKING THIS BOX, I CONFIRM THE PHARMACY AUTHORIZATION TERMS IDENTIFIED ON THE SECOND PART OF THIS ENROLMENT FORM.

☞ _____
Physician signature

Date (dd/mm/yyyy) _____ Physician licence # _____

TB: tuberculosis

CLEAR FORM

AMGEVITA®
adalimumab injection

Patient consent

General consent

I acknowledge that I have read and understand the information below and consent to the collection, use, and disclosure of my personal information, including personal health information, by McKesson, Amgen, and their authorized agents and service providers for the purposes as explained below. Furthermore, I acknowledge that the dispensing and delivery of my medication will be performed by a pharmacy of my choosing (the "**Participating Pharmacy**"). I further consent to being contacted from time to time by McKesson, Amgen, or their authorized agents for the purposes explained below. I acknowledge that the Program is sponsored by Amgen and is administered by McKesson, a third-party service provider, on behalf of Amgen and that certain aspects of the Program may be provided by authorized third parties (for example to administer, train, or assist in therapy). Additional service providers may be appointed by Amgen or McKesson to administer or support the Program from time to time. The personal information that I and/or my healthcare providers (including my doctor and pharmacy), insurers, or payers provide to the Program, including my name, contact information, and prescription information, will be used to manage and administer the Program or provide Program services to me, including reimbursement assistance and administering, training, or assisting in therapy (e.g., self-injection training), medication delivery, and provision of information about the Program. I understand that Amgen has a legal obligation to report adverse drug events to various local and international health authorities and to monitor product complaints. Personal information provided to the Program may be (i) monitored by Amgen or its service providers for safety-related data and product complaints in order to ensure compliance with these legal reporting requirements, and (ii) reported to local or international health authorities. Amgen may contact me or my physician for additional information to fulfill its reporting obligations. My personal information may be combined with the information of others who participate in the Program in order to generate aggregated data that does not contain identifying information ("**Aggregated Data**"). Aggregated Data may be used by Amgen and its service providers to improve and/or refine the Program to design and implement other patient programs and for research purposes including health economic studies and analysis, publications, and the identification of trends such as product utilization, adherence, or outcomes (including treatment outcomes). For these sole purposes, McKesson may on a confidential basis collect my personal information and share it with my healthcare providers, insurers and/or other payers, Amgen, and/or Amgen's agents and service providers (e.g., information technology providers). If, from time to time, another service provider is appointed by Amgen to administer the Program or provide Program services, my personal information will be transferred to this service provider to ensure the continuity of the Program services.

Amgen, McKesson, and their authorized service providers may store or process personal information outside of Canada (including in the United States), where local laws may require the disclosure of personal information to governmental authorities under circumstances that are different than those that apply in Canada. In addition, personal information may be used or disclosed to third parties when permitted or required by applicable laws, court orders, or government regulations (collectively, "Applicable Laws"). Personal information will be retained only for as long as is needed to fulfill the purposes for which it was collected and in order to comply with Applicable Laws. Industry-standard safeguards will be used to protect the security of the personal information that is collected. Any third-party service provider engaged to support the Program will be required to comply with the terms of this consent.

You may contact the Program's Privacy Officer at any time to update or access your personal information, modify or withdraw your consent (in part or in full), express a privacy-related concern, or inquire about the privacy practices of the Program (including those related to foreign information processing). The Privacy Officer can be reached at privacycanada@amgen.com or Amgen Canada Inc., Attn: Data Protection Officer, 6775 Financial Drive, Suite 100, Mississauga, ON L5N 0A4. Please note that if you modify or withdraw your consent, your ability to receive the Program services may be limited.

Consent if I am enrolled for more than one medication under the Program

I am enrolled under the Program for one or more other medications that have been prescribed for me by the same doctor who prescribed AMGEVITA® therapy. I agree that information about all of my enrolments under the Program can be combined and shared in combination form with my prescribing doctor. I understand that this will be done in order to improve and/or refine the Program and the services received by me thereunder. I understand that I may withdraw my consent for this use of my information at any time by contacting the Program.

Consent to being contacted for surveys/marketing purposes

I consent to being contacted from time to time by McKesson, Amgen, or their authorized agents for the purpose of completing confidential surveys about the Program. I understand that I may withdraw my consent to be contacted for this purpose at any time by contacting the Program.

Pharmacy authorization

I authorize McKesson to be my designated agent to forward the prescription indicated above, by fax or other mode of delivery, to the Participating Pharmacy chosen by the above-named patient. This prescription represents the original of the prescription drug order. The chosen pharmacy is the only intended recipient, and there are no others. The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.

Please note that enrolment forms without completed official prescription information will not be processed.

This document may contain private and confidential information and is intended only for the person(s) named on the reverse. If you are not a named addressee, you should not disseminate, distribute, or copy this document. If you have received this document by mistake, please notify the sender immediately and then destroy this document. We thank you for your cooperation and assistance.

Enliven®
PATIENT SUPPORT PROGRAM

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REVIEWED BY PAAB

MEMBER OF INNOVATIVE MEDICINES CANADA

BIOTECHNOLOGY BY AMGEN®