cimzia Solutions®

Patient Support Program

Enrolment Form

Please fax to 1-877-820-6107
OR call 1-800-908-5555
to enrol today!

PATIENT INFORMATION (PLEASE PRINT) TO BE COMPLETED BY PATIENT

First and Last Name:	Gender: ☐ Male ☐ Female
Street Address:	
City:	Province: / Postal Code:
Home Telephone: ( )	Work Telephone (optional): ( )
Mobile (optional): ( )	Email (optional):
Date of Birth (YYYY/MM/DD): / /	Best Time to Contact: ☐ AM ☐ PM ☐ Other

PLEASE READ THE CONSENT AND DISCLOSURE SECTION ON THE REVERSE OF THIS FORM AND SIGN IN THE SPACE BELOW.

I, the undersigned, have read the terms and conditions found on the reverse of this form, understand the services offered by the Program and agree to the collection, use, disclosure and storage of my personal information and personal health information in accordance with those terms and conditions.

Signature of Patient or Legal Representative: _____ Date of Signature (YYYY/MM/DD): / /

Legal Representative's Relationship to Patient: _____

FOR PROMPT ASSISTANCE CALL 1-800-908-5555

PHYSICIAN INFORMATION TO BE COMPLETED BY PHYSICIAN

Prescribing Physician (print full name):

Primary Contact / Location:

Telephone: ( ) Fax: ( )

PHYSICIAN ADDRESS STAMP

CIMZIA® (certolizumab pegol) INFORMATION

Patient Diagnosis:
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis _____
- ☐ Psoriatic Arthritis _____
- ☐ Other medical conditions (specify) _____

Device: ☐ Pre-filled Syringe DIN 02331675 ☐ Autoinjector DIN 02465574

Patient Allergies: ☐ No ☐ Yes (specify) _____

Patient on beta blocker/ACE Inhibitor: ☐ No ☐ Yes (specify) _____

Dosage Instructions:

- ☐ Starting dose of 400 mg SC at week 0, week 2, and week 4 followed by:
- ☐ Maintenance dose of 200 mg SC every 2 weeks with _____ repeats
- ☐ Maintenance dose of 400 mg SC every 4 weeks with _____ repeats
- ☐ Special request _____
- ☐ Request for injection training

Tuberculosis (TB) Assessment

Date TB assessment completed (YYYY/MM/DD): / /

Are the following TB tests: Completed ☐ or Required ☐

Purified Protein Derivative (PPD) Results

PPD: ☐ Yes ☐ No

Results: ☐ Positive ☐ Negative ☐ Pending

Date (YYYY/MM/DD): / /

Chest X-ray (CXR) Assessment

CXR: ☐ Yes ☐ No

Results: ☐ Positive ☐ Negative ☐ Pending

Date (YYYY/MM/DD): / /

Physician Signature: _____ **Date (YYYY/MM/DD):** / /

Physician Acknowledgement

My signature acknowledges that:

- I am the prescribing physician of this patient.
- The patient has been prescribed certolizumab pegol (CIMZIA).
- Subject to the above-noted patient's consent, and only to the extent of such patient's consent,
  - —I consent to UCB contacting me with regard to the above-noted patient to assist it in administering the Program and, without limitation, with regard to reimbursement, injection training and patient care; and
  - —I consent to UCB receiving, collecting, storing, using and disclosing any of my information regarding and any information that I provide with respect to the patient that is necessary to assist the patient in obtaining any services or assistance the patient has authorized and consented to.
  - — **I agree to allow UCB to provide this script to the pharmacy chosen by the above named patient. This script represents the original prescription drug order**

Any reference to UCB in this form includes UCB Canada Inc. and its affiliates and their respective employees, consultants, agents and representatives, including, without limitation, third party service providers.

We are here for you!

cimzia® (certolizumab pegol)

CIMZIA Solutions®

Patient Support Program

Enrolment Form

PATIENT CONSENT TO COLLECTION USE AND DISCLOSURE (BY SIGNING ON THE REVERSE SIDE OF THIS FORM)

Consent to Use of Personal Information

Use

I understand that the personal information I provide to UCB, including in this form, as well as all personal information collected by UCB with my permission from my health care provider, will be used for the administration of the CIMZIASolutions® Program (the Program).

Consent

I consent to the collection, use, disclosure and storage of:

- my personal information (Personal Information), including, without limitation, my name, date of birth, address, phone number and email address; and
- my personal health information (Personal Health Information), including, without limitation, information relating to my medical condition and treatment by my prescribing physician(s), pharmacist(s), private insurance company(ies), public payer(s) and any other health care provider or payer that may possess the requisite information, including UCB by UCB for the purpose of my participation in the Program and for the purposes set out in this form.

I understand UCB will use my Personal Information and my Personal Health Information to:

- verify my insurance coverage and/or otherwise to arrange for reimbursement for CIMZIA® certolizumab pegol (CIMZIA);
- coordinate delivery of CIMZIA® to me;
- arrange for injection training;
- provide me with educational and support services associated with CIMZIA® therapy;
- provide me with reminders regarding my therapy;
- provide me with a sharps disposal program;
- conduct market analyses or other commercial analyses, including aggregating my Personal Information and Personal Health Information with other data for such analyses; and
- administer all aspects of the Program, as the Program may change from time to time.

I understand that my Personal Information and Personal Health Information may be collected, used and/or stored outside of my province or territory or country, and that the laws of those countries regarding privacy may be less stringent than the laws of Canada and its provinces.

I agree to be contacted in the future for information regarding my condition, my CIMZIA® treatment or any other information required for the administration of the Program by UCB.

I consent to UCB leaving messages for me, either by e-mail, or by voicemail at the addresses and number(s) provided.

I consent to receive educational support materials, services and information from the Program for people who are taking CIMZIA®.

Disclosure

I understand that UCB will only disclose Personal Information and Personal Health Information only as needed in connection with the provision of the Program or required by law. For example:

- UCB may disclose my Personal Information and/or Personal Health Information to my health care provider, my pharmacist and third party service providers for the purpose of administering the Program, administering therapy or providing training in relation to therapy and to insurers for the purpose of reimbursement assistance; or
- UCB may have to contact my health care provider in the case of an adverse drug event, including a serious adverse drug event, and UCB may be required to report such serious adverse drug events to Health Canada.

Treatment of Personal Information and Personal Health Information

I understand that UCB, its affiliates and their respective employees, consultants, agents and representatives, including, without limitation, third party service providers, will have access to my Personal Information and Personal Health Information and all the information collected and recorded in the Program will be treated and maintained by UCB as strictly confidential in compliance with applicable privacy and health privacy legislation and with UCB's privacy policy. I can obtain a copy of UCB's privacy policy by sending a written request to UCB Canada Inc., 2060 Winston Park Drive, suite 401, Oakville, Ontario L6H 5R7 or at http://www.ucb.com/legal.

Correcting Personal Information

Except where the law prohibits me from doing so, I understand I may obtain a copy of my Personal Information and my Personal Health Information and can correct any errors by contacting UCB at the address set out above.

Withdrawing Consent

I understand that I can withdraw my consent at any time by writing to CIMZIASolutions,® 2060 Winston Park Drive, Suite 401, Oakville, Ontario L6H 5R7.
I understand that withdrawing my consent will result in the termination of my enrolment in the Program.
I understand that any withdrawal of my consent will not be retroactive and any activities relating to information collected, aggregated, used, stored, and/or disclosed prior to my withdrawal will not be affected and any previously collected Personal Information or Personal Health Information can continue to be used, stored and disclosed if there is no personal identifying information.

Changing the Program

I understand that UCB may change, modify or discontinue the Program at any time without notice to me.

Any reference to UCB in this form includes UCB Canada Inc. and its affiliates and their respective employees, consultants, agents and representatives, including, without limitation, third party service providers.

CIMZIA® (certolizumab pegol)