UCBCares™
Patient Support Program

Patient Support Program

Rheumatology Enrolment Form

Please fax to **1-877-820-6107** or email **enrolments@ucbcares.ca**

Patient Information (please print) — To be completed by patient

First and Last Name:		Gender: ☐ Male ☐ Female ☐ Other
Date of Birth (YYYY/MM/DD): / /	Health Card Number:	Version Code:
Call Preference: ☐ Home ☐ Mobile ☐ Other:		
Home Telephone: ( )	Consent to leave message: ☐ Yes ☐ No	
Mobile (optional): ( )	Consent to send SMS (text message) ☐ Yes ☐ No	
Email (optional):	Consent to receive email communication: ☐ Yes ☐ No	
Street Address:	City:	Province: / Postal Code:

☐ Patient consent obtained

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.

For prompt assistance call **1-800-908-5555**

Signature of Patient: ______ Date of Signature (YYYY/MM/DD): / /

Physician Information — To be completed by physician

Prescribing Physician (print full name):	Primary Contact/Location:
Telephone: ( )	Fax: ( )

PrCIMZIA® (certolizumab pegol) Information

Rx

Patient Diagnosis:
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Non-radiographic Axial Spondyloarthritis
- ☐ Psoriatic Arthritis
- ☐ Other medical conditions (specify) ______

Device:
- ☐ Pre-filled Syringe (200mg/mL) DIN 02331675
- ☐ Autoinjector (200mg/mL) DIN 02465574

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 ______ months
- ☐ Maintenance dose of 400 mg SC every 4 weeks ______ months
- ☐ Special request ______

Medical Information

Is the patient medically cleared to start therapy?
☐ No ☐ Yes If no, why: ______

Patient allergies:
☐ No ☐ Yes (specify) ______

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

Does the patient require QFT Testing:
☐ No ☐ Yes

Injection services required:
☐ No ☐ Yes

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 CIMZIA (certolizumab pegol).
- 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 and UCBCares are trademarks of the UCB Group of Companies.

PrCIMZIA® (certolizumab pegol)

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Patient consent and disclosure (by signing on the reverse side of this form)

Consent to Use of Personal Information

The UCBCares™ Program ("UCBCares™" or "Program") is a program that is funded by UCB Canada Inc., 2060 Winston Park Drive, Suite 401, Oakville, Ontario L6H 5R7. The Program is administered by a third party service provider ("Program Administrator").

Use

I understand that the personal information I provide to UCB, including in this form, as well as all personal information collected by UCBCares™ with my permission from my health care provider, will be used for the administration of UCBCares™ as described herein.

Consent

I consent to the collection, use, disclosure and storage of the following information by UCBCares™:

- 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 UCBCares™ will use my Personal Information and my Personal Health Information to:

- verify my insurance coverage and/or otherwise to arrange for reimbursement;
- coordinate delivery of medication to me;
- arrange for injection training;
- provide me with educational and support services associated with my 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 treatment or any other information required for the administration of the Program by UCBCares™.

I consent to UCBCares™ leaving messages for me, either by email, text message or by voicemail at the addresses and number(s) provided.

I consent to receive educational support materials, services and information from the Program.

I understand that UCB Canada Inc. reserves the right to appoint third party service providers to administer the program and I consent to my information being transferred to any future service provider administering the Program.

Disclosure

I understand that UCB Canada Inc. does not, in the normal course, access my Personal Information and my Personal Health Information and relies on the Program Administrator to do so when administering the Program; however, UCB Canada Inc. may directly access Personal Information and Personal Health Information in limited circumstances, for example, to transfer Personal Information and Personal Health Information to a new Program Administrator, to perform audits of the Program in order to evaluate or improve the Program, or for regulatory reporting purposes (e.g. reporting adverse reactions to a government agency). The Program Administrator may provide UCB Canada Inc. with de-identified or aggregate information collected in the course of the Program, which may be used by UCB Canada Inc. for clinical research, market research or internal evaluation purposes.

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

- UCBCares™ 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
- UCBCares™ 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.

I understand that any financial assistance provided as a result of my enrolment in the Program may be reportable income to public or private payers or government agencies and I understand that I am solely responsible for such reporting and for ensuring compliance with accepting any such financial assistance.

Treatment of Personal Information and Personal Health Information

I understand that UCBCares™ will collect, have access to, use, store and disclose my Personal Information and Personal Health Information as described herein and all the information collected and recorded in the Program will be treated and maintained as strictly confidential in compliance with applicable privacy and health privacy legislation and with UCB privacy policy. I can obtain a copy of the UCB Canada Inc. privacy policy by vising the website 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 UCBCares™ at the address set out above.

Withdrawing Consent

I understand that I can withdraw my consent at any time by writing to UCBCares™, 2201 Bristol Circle, Suite 602, Oakville, Ontario, L6H 0J8.
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.

Financial Assistance

I understand that any financial assistance provided to me may be reportable income to public or private payers or government agencies. I understand that I am solely responsible for such reporting as well as for ensuring compliance with accepting any such financial assistance.

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, Program Administrator and other third party service providers

CIMZIA®
(certolizumab pegol)