XPOSE® program enrollment and consent form:

For patients prescribed PrCOSENTYX® (secukinumab) for psoriatic arthritis or ankylosing spondylitis

Telephone: 1-844-27XPOSE (1-844-279-7673)
Fax: 1-866-872-5771

All sections MUST be completely filled out

Patient information (please print)

First name

Last name

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

( ) –

Preferred telephone ☐ Home ☐ Work ☐ Mobile

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening

E-mail ☐ I consent to receive e-mails related to the Program from Novartis.

Preferred mode of communication: ☐ Phone ☐ E-mail

Address

City

Province Postal code

Preferred language: ☐ English ☐ French

☐ I agree to be contacted for market research purposes and studies.

PsA assessment details

HAQ:

CRP:

BASDAI:

DAS-28:

Radiographic evidence:

Previously treated? ☐ Yes ☐ No

If yes, previous treatment:

AS assessment details

BASDAI:

BASFI:

HAQ:

Spinal pain VAS (cm):

Radiographic evidence:

Previously treated? ☐ Yes ☐ No

If yes, previous treatment:

Patient signature

I have read and agree to the patient consent on the reverse side of this form.

X _____ _____

Patient signature **Date** (mm/dd/yyyy)

Referring physician (please print or stamp)

First name Last name

License #

Address City Province Postal code

Office contact name

( ) - Telephone ( ) - Fax

Preferred mode of communication: ☐ Phone ☐ E-mail

E-mail ☐ I consent to receive e-mails related to the Program.

Prescription information

COSENTYX® (secukinumab) for subcutaneous injection

Diagnosis: ☐ Psoriatic arthritis ☐ Ankylosing spondylitis

COSENTYX® format:

☐ SensoReady® pen ☐ Pre-filled syringe

Dosing for psoriatic arthritis ☐ 150 mg sc

For psoriatic arthritis patients with moderate to severe plaque psoriasis ☐ 300 mg sc

For psoriatic arthritis patients who are anti-TNFα inadequate responders and who continue to have active psoriatic arthritis ☐ 150 mg sc ☐ 300 mg sc

Duration of treatment (months):

COSENTYX® is administered at weeks 0, 1, 2, and 3, then monthly dosing starts at week 4.

Dosing for ankylosing spondylitis ☐ 150 mg sc

Duration of treatment (months):

COSENTYX® is administered at weeks 0, 1, 2, and 3, then monthly dosing starts at week 4.

Tuberculosis (TB) screening

TB test†

☐ Not required ☐ Required

Do you require the Program to schedule TB testing on your behalf?

☐ Yes ☐ No

Chest X-Ray† (CRX)

☐ Not required

☐ Required

Directives from the prescriber

I hereby confirm the prescription of COSENTYX® and permit COSENTYX® start at this time.

☐ Yes ☐ No

If no, please specify reason (e.g., awaiting test results):

Physician declaration

The XPOSE® program ("Program") is sponsored by Novartis Pharmaceuticals Canada Inc. ("Novartis") and currently managed by Innomar Strategies Inc. ("Program Administrator"), an independent third-party contracted by Novartis to administer the Program. The Program includes services regarding COSENTYX® ("Novartis medication") and the medical conditions it is used to treat. Novartis reserves the right to modify or terminate the Program at any time without prior notice.

I hereby confirm that I am the healthcare provider of the patient identified on this Enrollment and Consent Form. Furthermore, I confirm that my patient has been prescribed COSENTYX® for an approved indication as per approved product monograph, as indicated on this form. I agree to provide background information on the Program to patients prior to their enrollment and I will only provide patient information as part of the Program, where applicable, with the patient's express consent.

I understand that the information I provide to the Program Administrator, including information on this form ("my information"), will be used by the Program Administrator and may be shared with Novartis. The Program Administrator will not share patient identifiable information with Novartis, other than as required for adverse event reporting, but may share de-identified patient data to enable Novartis and/or the Program Administrator to assess and improve patient assistance programs and how it provides products and services to patients and healthcare professionals, or as otherwise permitted by law. I agree that I may be contacted by the Program Administrator for information required for the administration of the Program, by email, phone, fax or otherwise, using the contact information that I have provided above.

I understand that the file containing my information will be maintained at the offices of the Program Administrator. Authorized employees, agents and mandataries of the Program Administrator may have access to my information where necessary in order to render the services or for purposes described in this form. Information on Novartis' policies and practices regarding privacy, including (i) how to obtain a copy of its privacy policy, (ii) how to request access to, or correction of, my personal information, (iii) how to withdraw my consent, is described in the Patient Consent section of this form.

I acknowledge that adverse events may be reported about my patients who are participating in the Program during the course of their participation in the Program. I understand I may be contacted by Novartis or the Program Administrator to provide follow-up information relating to adverse events. Adverse event reports may need to be forwarded to regulatory authorities in and outside of Canada.

X _____

Physician signature

Date (mm/dd/yyyy) _____

† Specific TB results will be reported back to the requester by the Program. Any follow-up on positive TB is at the discretion/responsibility of requester.

Cosentyx secukinumab

XPOSE®

Recommended dose for psoriatic arthritis

	• 150 mg sc
For psoriatic arthritis patients with moderate to severe plaque psoriasis	• 300 mg sc
For psoriatic arthritis patients who are anti-TNFα inadequate responders and who continue to have active psoriatic arthritis	• 150 mg sc • 300 mg sc

COSENTYX® is administered at weeks 0, 1, 2, and 3, then monthly dosing starts at week 4.

Recommended dose for ankylosing spondylitis

- 150 mg sc

COSENTYX® is administered at weeks 0, 1, 2, and 3, then monthly dosing starts at week 4.

COSENTYX® is intended for use under the guidance of a health care professional. Patients may self-inject after proper training and when deemed appropriate.

Prescribers are advised to periodically reassess the need for continued therapy.

Patient consent

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I have been given the opportunity to discuss this Program with my healthcare provider. I understand that my participation in the Program is voluntary and if I choose not to participate, this will not impact my medical treatment or insurance coverage eligibility. However, if I do not sign this form, I will not be able to participate in the Program and receive assistance from the Program Administrator, as described above.

I understand the Program Administrator may collect information from, and share information with, my healthcare providers and their staff, including my physician(s), nurse(s) and pharmacist(s), as well as healthcare providers employed or retained by the Program Administrator for the purposes of the Program (collectively, "Healthcare Providers"), insurance providers (private or public) as well as other service providers as necessary to provide me with services under this Program or to monitor or audit the services provided by the Program, but will not use my information for any other purpose unless required or permitted by law. The information collected and shared may include information about my contact information, date of birth, insurance coverage, prescription, medical condition and other health information, as well as my information included on this form (collectively, "Personal Information"). I authorize my healthcare provider to provide the Program Administrator with this completed form. I agree I may be contacted by the Program Administrator, Healthcare Providers or others in order to provide me with services under the Program, by email, phone or otherwise using the contact information that I provided. I acknowledge that I am responsible for any charges by my cellular phone provider should I choose to be contacted on my cellular phone for the purposes of the Program.

I understand Novartis and/or the Program Administrator may receive de-identified data from this Program for commercial or publication purposes, but will not receive my personally identifiable information, except for adverse event reporting purposes to enable Novartis to follow-up with my Healthcare Provider(s). This is necessary for Novartis to maintain the most up to date records as to the safety of its products. Adverse event information may need to be reported to health authorities in and outside of Canada.

If Novartis appoints a new Program Administrator to replace Innomar Strategies Inc., I agree that my Personal Information may be transferred to the new service provider.

I understand that the Program is not intended to provide medical advice or medical diagnoses. I agree to always seek the advice of my physician or other qualified healthcare provider if I have health concerns, and not to disregard professional medical advice based on information read or conveyed as part of the Program.

I understand the file containing my Personal Information will be maintained at the offices of Innomar Strategies Inc. Authorized employees, agents and mandataries of Innomar Strategies Inc. will have access to my Personal Information as necessary to administer the Program. Personal Information collected in connection with the Program, including any adverse event information collected about me (eg. initials, date of birth, gender, but not name) may be stored or processed outside of Canada, where it may be subject to the laws of foreign jurisdictions. For information about Novartis' privacy policies and practices, I can contact Novartis at the phone number provided below or access a copy of Novartis' privacy policy at https://www.novartis.ca/en/privacy-policy.

I have the right to revoke this consent at any time by contacting the Program, at 1-844-279-7673. However, I understand that withdrawing my consent will result in the termination of my enrollment in the Program. Further, the withdrawal of my consent will not have a retroactive effect with respect to information about me already collected and disclosed. I may request access to, or correction of, my Personal Information at any time by contacting the Program Administrator at Cosentyx@innomar-strategies.com.

I hereby confirm that I have read and understood the information provided about the Program included on this XPOSE® Program Enrollment Form. I have also read and understood the Patient Consent section of this form which describes how my Personal Information will be collected, used or disclosed and I consent to participate in the XPOSE® program.

COSENTYX® (secukinumab) is indicated for the treatment of:

- Adult patients with active psoriatic arthritis when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. COSENTYX® can be used alone or in combination with methotrexate
- Adult patients with active ankylosing spondylitis who have responded inadequately to conventional therapy

Consult the Product Monograph at www.novartis.ca/CosentyxMonograph for contraindications, warnings, precautions, adverse reactions, interactions, dosing, and conditions of clinical use. The Product Monograph is also available by calling 1-800-363-8883.

For program-related inquiries, please call the XPOSE® program at 1-844-27XPOSE (1-844-279-7673)

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PAAB

MEMBER OF INNOVATIVE MEDICINES CANADA

Cosentyx secukinumab

XPOSE®