ENROLLMENT AND CONSENT FORM

BIO ADVANCE™

Please Fax to your Bioadvance™ Coordinator

Name:

Tel.:

Fax:

Patient Information

Patient Name:

Date of Birth:

Tel.:

Can leave a message at this phone number ☐ YES ☐ NO

Rx

Physician Name:

Physician License Number:

PHYSICIAN STAMP

Drug: SIMPONI™ (Golimumab)
☐ SmartJect™ Autoinjector (DIN 02324784)
OR
☐ Pre-filled Syringe (DIN 02324776)

Directions: Inject 50 mg (0.5 ml) subcutaneously, once monthly

Duration:

Repeats:

Physician Signature: **Date:**

Prescriber certification: I certify that this prescription is an original prescription and this pharmacy is the only receiver. The original will not be reused.

Pharmacist:

I agree to permit my healthcare provider(s) to disclose to the BioAdvance™ Coordinator assigned to managing my patient file, or his/her replacement (where applicable) (the "BAC") my personal information in order for me to benefit from the services offered by the BAC. Such Personal Information may include my name, date of birth, phone number and any other Personal Information included on my prescription. Personal Information may be collected by the BAC from my healthcare provider(s) or me, and may thereafter be disclosed to my healthcare provider(s) or my pharmacist, but only as is reasonably necessary to facilitate the sharing of information, as necessary, between the BAC, my healthcare provider(s), my pharmacist and myself, for the purpose of obtaining my prescription for SIMPONI™.

Once my Personal Information has been disclosed by my healthcare provider(s) or myself to the BAC, federal privacy laws may no longer protect the information from further disclosure. However, the BAC is bound by other laws to protect my information by using and disclosing it only for the purposes described above or as permitted or required by law. My Personal Information will not be used or disclosed by the BAC for any other purpose unless information that identifies me directly is first removed, e.g. name, social insurance number. These limitations continue even after the present authorization (the "Authorization") expires (ends) or I revoke (take back) this Authorization.

I understand that:

- I do not have to sign this Authorization, but if I do not, the BAC will not be able to transmit this SIMPONI™ prescription to my pharmacist and I would need to bring the prescription myself to my pharmacist;
- My healthcare provider will not condition my medical treatment on my agreement to sign this Authorization;
- I may revoke (take back) this Authorization at any time by mailing or faxing signed letter(s) of revocation to my healthcare provider(s), but if I do so, the BAC will be unable to assist my healthcare provider(s) in obtaining my prescription for SIMPONI™.
- Revoking this Authorization will prohibit disclosure of my health information by my healthcare provider(s) after the date my letter of revocation is received and processed, but will not affect the BAC's ability to use and disclose information already received;
- I am entitled to a copy of this Enrollment and Consent Form; and
- If I want to access my patient file maintained by the BAC and/or make changes or corrections to it, I may do so by written request to the currently active BAC.

Patient Signature: **Date:**

99-224800

Simponi for me™ support program

1 - File Copy, 2 - Patient Copy