ENROLMENT FORM

Fax completed form to 1-855-489-3935 (EXEL)

PATIENT INFORMATION (to be completed by patient)

LAST NAME _____

FIRST NAME _____

GENDER ☐ F ☐ M

DATE OF BIRTH (YY/MM/DD) _____

PHONE NUMBER _____
Best phone number to contact me

_____
Alternative phone number

Best time to be contacted (M-F) _____

_____

☐ **Can leave a message**

INSTRUCTIONS _____

I REQUIRE LANGUAGE ASSISTANCE ☐ YES

PLEASE SPECIFY LANGUAGE _____

EMAIL* *(OPTIONAL)* _____

*By providing your electronic address, you consent to receiving electronic communications containing information and updates relating to the **eXel Program**.‡ The **Administrator**¶ (Innomar Strategies Inc. and its affiliates, the company that runs the **eXel Program**) is seeking your consent on behalf of Pfizer Canada Inc., the sponsor of the Program. You can withdraw your consent to receive electronic communications by following the instructions provided in the electronic communication. You can contact the Program Administrator at any time by calling 1-855-XEL-EXEL (935-3935) or at: **eXel Program**. P.O. Box 34586, 3131 Côte-Vertu, Ville St-Laurent, QC H4R 2P4.

☐ I have read, understand, and agree to the patient consent statement on the reverse.

_____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

_____
DATE

_____
PRINTED NAME OF LEGAL REPRESENTATIVE

_____
RELATIONSHIP OF LEGAL REPRESENTATIVE TO PATIENT

PHYSICIAN INFORMATION (to be completed by physician)

PHYSICIAN NAME _____

LICENSE NUMBER _____

ADDRESS _____

_____

PHONE NUMBER _____

FAX NUMBER _____

ALTERNATIVELY, PHYSICIAN INFORMATION
CAN BE STAMPED IN THIS SPACE

PRESCRIPTION INFORMATION

☐ NEW ENROLMENT ☐ RENEWAL

☐ 5 mg twice daily (recommended dosing)

☐ 5 mg once daily (see Product Monograph for dosage adjustment in special circumstances)

QUANTITY ☐ For 1 month Other: _____

NUMBER OF REPEATS _____

DIAGNOSIS ☐ Moderate-to-severe RA

XELJANZ START DATE ☐ As soon as possible

Other: _____

☐ I have read, understand, and agree to the physician consent statement on the reverse.

_____
SIGNATURE OF PHYSICIAN

_____
DATE

Do you require Pfizer Canada's Drug Safety Unit to contact you regarding information shared on this form or any accompanying document?

☐ YES ☐ NO

ADDITIONAL NOTES _____

_____

To reach the XELJANZ customer support program, ☎ call 1-855-935-3935 (XEL-EXEL)

For complete prescribing information, please refer to the XELJANZ Product Monograph.
The Product Monograph is available upon request.

Working together for a healthier world®

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MEMBER OF INNOVATIVE MEDICINES CANADA PAAB

Pr XELJANZ™ (tofacitinib citrate)

PATIENT CONSENT

Agreement to Disclose Personal Information – eXel Program

Special Instructions: This consent form may contain words or phrases that are new to you. If any part of this form is not clear to you, please ask the person who gave you this form to explain it to you. Words that are written in **bold type** are explained on the bottom of this form.

We are asking for your permission to collect and to share your **Personal Information**.† The patient assistance program for XELJANZ, called **eXel Program**‡ ("Program") is a free Program offered to all patients who have been prescribed XELJANZ. The Program can help you in a number of ways. Sharing your **Personal Information** will help us figure out which Program services and materials are best for you.

For you to take part in the Program and for us to carry out the Program activities for you, you have to agree to:

- Allow your **Healthcare Providers**§, the **Administrator**¶ (the company that oversees and runs the Program) and the **eXel Program Personnel**†† ("Program Personnel") to collect, use, share with each other, and store your **Personal Information**. These people are described at the bottom of this form.
- Allow the Program Personnel to contact you about your **Personal Information** or any other information needed or related to the Program. For example, this may include, asking for your feedback on the quality of the services offered by the Program, your progress while taking the medication XELJANZ, and any other related services. Program Personnel may leave messages for you at the phone number you give them, if you have checked the *Can leave a message* box on this enrolment form.
- Allow Pfizer Canada (the company that sells XELJANZ) and its affiliates ("Pfizer") to collect your **Personal Information** and information on any unwanted drug effects ("adverse drug events", or side effects) that you may have while taking XELJANZ or other medications made by Pfizer. Commonly, Pfizer and Health Canada (the government body that approves the use of this and other medications) ask for this information to track the safety record of these medications. The information collected from you and others taking these medications allows them to better understand how these medications can affect the patients who take them. Pfizer may also contact the Administrator or your Healthcare Providers if they need more information on the adverse drug event.

By giving your consent, you understand that:

- You agree to receive Program services, support and materials suitable for your needs.
- The Program Personnel are not allowed to collect, use, share or store your **Personal Information** for anything other than the activities described above. They cannot share any of your **Personal Information** with anyone other than your Healthcare Providers, unless the **Health Information**† that identifies you is removed. For example, your name, address and any personal identifiers must be removed if any of your **Health Information** is shared with anyone who is not your Healthcare Provider. **Health Information** which does not have your name, address or personal identifiers could still be shared after you withdraw your consent.
- You may take back your consent at any time by sending a request with your signature to the Administrator. You can either mail the signed request to the address below or you can fax it to the fax number at the top of this page. Your consent is needed to receive help from the **eXel Program**. If you decide to take back your consent, you will not be allowed to be part of the **eXel Program**. This means that you will not be able to receive any support from the Program, and you may not be able to get financial help for XELJANZ if you are eligible.
- Except where prohibited by law, you may have a copy of your **Personal Information**. You can correct any mistakes and/or ask the Administrator any questions about the collection, use, sharing and storage of your **Personal Information**. You may contact the Administrator at the address below.
- Any calls to or from the Administrator while providing services of the Program may be monitored or recorded for control of quality and to train their personnel.
- Your **Personal Information** may be collected, used, shared and/or stored outside of your province or territory or country. The laws of those countries regarding privacy may be less strict than the laws of Canada and its provinces.
- Your **Personal Information** may also be disclosed and/or transferred to a third party in the event of a proposed or actual purchase, sale (including a liquidation, realization, foreclosure or repossession), lease, amalgamation or any other type of acquisition, disposal, transfer, conveyance or financing of all or any portion of Pfizer Canada or of any of the business or assets or shares of Pfizer Canada or a division thereof.
- Pfizer Canada has the right to cancel the Program and the services offered by the Program at any time.
- If at any time and for any reason Pfizer Canada appoints a new Program Administrator, you will allow the transfer of your **Personal Information** by the Administrator to the new Administrator to continue your participation in the Program.
- You will not seek to have the amount of support you receive by way of this program counted in any Government out-of-pocket expenses for prescription drugs.

† Your **Personal Information** includes your individual information (name, gender, address, phone number, date of birth, etc.), your financial information and your **Health Information** (medical history, medical condition(s), information relating to your treatment, and information relating to your health insurance, etc.).

‡ The **eXel Program** is sponsored by Pfizer Canada to help patients get access to XELJANZ and to help them manage their treatment plan for rheumatoid arthritis.

§ **Healthcare Providers** include all of your doctors, nurses, pharmacists, private insurance company(s), public payer(s) and any other healthcare provider or payer that may possess the necessary information.

¶ The **Administrator** is the company Innomar Strategies Inc. and its affiliates – they run the **eXel Program**. They can be contacted at: **eXel Program**, P.O. Box 34586, 3131 Côte-Vertu, Ville St-Laurent, QC H4R 2P4.

†† **eXel Program Personnel** include the employees and consultants of the Administrator (Innomar Strategies Inc. and its affiliates).

PHYSICIAN CONSENT

My signature acknowledges that:

- I am the prescribing physician of this patient;
- I have prescribed this patient XELJANZ for a Health Canada approved indication;
- Subject to the above-noted patient's consent and only to the extent of such patient's consent:
  - I consent to the **eXel Program Personnel**† contacting me with regard to the above-noted patient to assist it in administering the program, and without limitation with regard to patient reimbursement, and patient care;
  - I consent to the **Administrator**‡ receiving, collecting, storing, using and disclosing any of my information that I provide in 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 consent to Pfizer Canada (the company who sells XELJANZ) and its affiliates ("Pfizer") to contact me with regard to the above-noted patient if they require further information on any adverse drug event pertaining to XELJANZ or other medications manufactured by Pfizer;
  - I agree to allow the Administrator to provide this prescription to the pharmacy chosen by the above-named patient or another pharmacy (where applicable) to ensure the patient obtains access to the therapy I have prescribed;
  - I agree to allow the Administrator to contact me for any other information regarding the **eXel Program**§ that would result in enhancing the delivery or the quality of services offered by this program to my patient.

† **eXel Program Personnel** include the employees and consultants of the Administrator (Innomar Strategies Inc. and its affiliates).

‡ The **Administrator** is the company Innomar Strategies Inc. and its affiliates – they run the **eXel Program**. They can be contacted at: **eXel Program**, P.O. Box 34586, 3131 Côte-Vertu, Ville St-Laurent, QC H4R 2P4.

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eXel™ SUPPORT PROGRAM