Enrolment Form

CASE MANAGER'S NAME: _____
TELEPHONE: 1-877-979-3200 **FAX TO:** 1-877-681-5236 or **EMAIL TO:** ORP@bayshore.ca

ORENCIA response Program
MyORP.ca

PATIENT INFORMATION

Patient name: _____

Address: _____ City: _____ Province: _____ Postal code: _____

Home phone: _____ Cellular phone: _____ Office phone: _____

Email address: _____ Date of birth: _____ mm/dd/yy Gender: ☐ M ☐ F

☐ **Consent has been obtained to leave a message at the contact information provided above**

Patient ready to start ORENCIA®? ☐ Yes ☐ No If no, waiting for: _____

Consider patient for FASTSTART® program (Allows patients to start on ORENCIA upon receipt of first prescription if insurance coverage criteria are met)? ☐ Yes ☐ No

Insurance approval attached? ☐ Yes ☐ No

PHYSICIAN INFORMATION

Name of referring physician: _____

Physician license #: _____ Telephone: _____ Fax: _____

Signature of prescribing physician: _____ Date: _____ mm/dd/yy

DOSING INFORMATION FOR RHEUMATOID ARTHRITIS

Prescription type: ☐ New start ☐ Continued Tx / Renewal

Patient's weight: _____ ☐ lb ☐ kg Date of weight: _____ mm/dd/yy

PRE-BIOLOGIC SCREENING — TB TEST

☐ Not required ☐ Positive result Date: _____ mm/dd/yy

☐ Negative result Date: _____ mm/dd/yy

Reason not yet completed: _____

☐ Pr**ORENCIA® SC (abatacept)** Prefilled syringe: 125 mg/mL

DOSING INSTRUCTIONS

The first SC injection (regardless of weight) should be given within a day of the IV loading dose in ORENCIA-naïve patients. Patients switching from ORENCIA IV to SC administration should administer the first ORENCIA SC dose instead of the next scheduled ORENCIA IV dose with their MTX regimen.

SC dosing

Frequency: ☐ Weekly ☐ Weekly + MTX regimen
Repeats: ☐ x 6 months ☐ x 12 months

☐ **Patient able to receive IV loading dose**

IV Loading dose

IV loading dose required in ORENCIA-naïve patients
IV loading dose: Infuse over 30 minutes:

- ☐ 500 mg (2 vials) Patient weight <60 kg
- ☐ 750 mg (3 vials) Patient weight 60-100 kg
- ☐ 1000 mg (4 vials) Patient weight >100 kg

☐ **Patient unable to receive IV loading dose**
Initiate weekly injections of subcutaneous ORENCIA without the IV loading dose.

☐ Pr**ORENCIA® IV (abatacept)** 250 mg vial

DOSING INSTRUCTIONS

Infuse over 30 minutes:

- ☐ 500 mg (2 vials) Patient weight <60 kg
- ☐ 750 mg (3 vials) Patient weight 60-100 kg
- ☐ 1000 mg (4 vials) Patient weight >100 kg

Weeks 0, 2, 4 and then every 4 weeks thereafter

Repeats: ☐ x 6 months ☐ x 12 months

Where would you like your patient to receive their ORENCIA IV treatment?

_____

NOTES:

PATIENT CONSENT

☐ **I have read and agree to the terms and conditions of the ORENCIA RESPONSE PROGRAM® and the privacy statement within this form.**

Signature: _____ Date: _____ mm/dd/yy

I also consent to having the following person speak or be spoken to on my behalf:

First name: _____ Last name: _____

Email address: _____ Phone: _____

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PATIENT CONSENT TO ENROLMENT

I confirm that the information I have provided in this application for enrolment into the ORENCIA RESPONSE PROGRAM ("Program") is complete and accurate. I would like to enrol in the Program and receive educational and therapy support services designed for people taking ORENCIA provided by the Program. The Program is a customer service program currently administered by Bayshore HealthCare Ltd., a third-party provider of client-focused services and patient support programs ("Administrator"), and sponsored by Bristol-Myers Squibb Canada ("BMS"). I understand that BMS reserves the right at any time and without notice to modify the enrolment form or the Program, including its eligibility criteria and any other aspects of the Program or to discontinue the Program and terminate assistance.

I understand that one of the services provided by the Program may include, based on eligibility, assistance in coordinating reimbursement and/or financial assistance, compassionate use, infusions and nursing assistance for ORENCIA infusions and injections. I authorize my physician and my health insurance company to disclose to the Administrator and its authorized representatives my personal information, including my name, address, phone number, email address and personal health information relating to my medical condition, medical history, treatment, or financial information such as my insurance coverage. I authorize my personal information, including my personal health information, to be used by the Administrator for purposes of verifying my insurance coverage for ORENCIA and/or otherwise arranging for reimbursement for ORENCIA, coordinating delivery of ORENCIA to me, arranging training on or assistance with the administration of ORENCIA and providing me with other educational and support services associated with ORENCIA therapy (the "Services"). For the purpose of providing the Services of the Program, I hereby authorize and instruct the Administrator to obtain any medical and personal information relating to my enrolment in the Program from me, my authorized representatives, 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 necessary information. For the Program to provide me with the Services, my personal information may be collected, used and disclosed only as necessary for the delivery of care or support to me and in accordance with applicable law. I acknowledge that my personal information may be shared with persons involved in the Program and my treatment (i.e., Administrator and its authorized representatives and agents, my physician, pharmacists and other health care providers), or for providing and coordinating other Program Services for me or for purposes authorized by applicable law, unless I otherwise expressly so advise.

In addition, if at any time and for any reason BMS appoints a new administrator to replace the Administrator, I hereby consent to the transfer of my personal information by the Administrator to another third-party administrator for the purpose of continuing my participation in the Program. I also consent to the transfer of my personal information by the Administrator to any other "third-party" for purposes relating to the offering by the Program of additional Program features and services (such as tools, websites, mobile applications to manage my health condition).

With respect to BMS, I understand that non-personally identifiable information regarding Program participation and outcomes may be presented to BMS for its use. I authorize BMS to publish in scientific publications (e.g., medical journals or scientific conferences) the information it obtains through this program. Examples of publication content include, but are not limited to, data on previous drug use, drug retention rates, and disease progression. Rest assured that any personal information that could identify you will be removed before any information is shared with BMS so none of your personal information will be disclosed for the purposes of any publication nor will it be part of any publication. I also understand that BMS has a legal requirement to report any adverse drug events to Health Canada and I hereby authorize BMS to collect information on any adverse drug events I may experience while on ORENCIA in order to monitor its safety, meet its reporting requirements and to continuously assess its benefit-risk profile. My personal information and details of any adverse drug event occurring while on treatment with ORENCIA can be communicated to the Administrator and to BMS Pharmacovigilance. I also consent to BMS contacting my physician in case any further clarification regarding the adverse drug event is needed. I understand that all the information provided to BMS will be stored in the corporate safety database located in the United States for the period of time mandated by law, and may be shared with its group companies and regulatory authorities as required by laws and regulations.

With respect to the personal information collected as part of my enrolment and participation in the Program, I understand that I may contact the Administrator of the Program to speak with the Administrator's Privacy Officer for more information, to address any additional questions I may have and to find out how I can access my personal information.

I am aware that it is my right to refuse to sign the consent form and to refuse the collection, use and disclosure of my personal information, as outlined above, and that if I do not provide consent, I may not be eligible for the Program Services. I understand that I may cancel my enrolment and this consent at any time by mailing or faxing a signed request to the Program Administrator:

Bayshore HealthCare Ltd.
2101 Hadwen Road
Mississauga, ON L5K 2L3
Fax: 1-877-681-5236

My cancellation will be in effect upon receipt of the letter by the Administrator of the Program and any further collection, use and disclosure of my personal information will cease.

Bristol-Myers Squibb

ORENCIA (abatacept) SC

ORENCIA (abatacept) IV

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