ORENCIA RESPONSE PROGRAM®
CONSENT AND ENROLLMENT FORM

ORENCIA response Program®

TELEPHONE: 1-877-979-3200

FAX TO: 1-877-681-5236 OR E-MAIL TO: TEAMORENCIA@INNOMAR-STRATEGIES.COM

PATIENT INFORMATION

Last name: _____ First name: _____

Home telephone: _____ Work telephone: _____

Special instructions (language considerations, best time to call for information, etc.): _____

Date of birth: ____ ____ ____ (mm dd yy) Gender: ❑ M ❑ F

Address: _____ City: _____

Province: _____ Postal code: _____ E-mail address: _____

PHYSICIAN INFORMATION

Name of referring physician: _____

License #: _____ Telephone: _____ Fax: _____

REPORTING

The Program sends the physician a summary report (HAQ, # of infusions...) at specified intervals.

❑ Please do not send report

DOSING INFORMATION

Prescription type: ❑ New start ❑ Continued Tx Patient's weight: _____ ❑ lb ❑ kg

PRESCRIPTION

Signature of prescribing physician: _____ Date: _____

PrORENCIA® IV (abatacept) 250 mg vial

Infuse over 30 minutes:

❑ 500 mg (2 vials) ❑ 750 mg (3 vials) ❑ 1,000 mg (4 vials)

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

Repeats: ❑ x 6 months ❑ x 12 months

PrORENCIA® SC (abatacept) 125 mg/mL injection

Frequency: Weekly

IV Loading dose required ❑ Yes ❑ No

Loading Dose: Infuse over 30 minutes:

❑ 500 mg (2 vials) ❑ 750 mg (3 vials) ❑ 1,000 mg (4 vials)

Repeats: ❑ x 6 months ❑ x 12 months

Special instructions: _____

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

❑ Rheumatology clinic/MD office ❑ ORP Infusion Clinic ❑ ORP nurse at physician's office

❑ Hospital clinic ❑ At the patient's home ❑ Other _____

PLEASE READ THE CONSENT AND PERMISSION SECTION ON REVERSE AND SIGN IN THE SPACE BELOW.

I, _____, the undersigned, have read the terms and conditions and:

- I understand and agree with the services offered by the ORENCIA RESPONSE PROGRAM® and the Consent and permission on the reverse side of this form.
- I agree to the transfer of my personal information to Bristol-Myers Squibb Canada in accordance with the Consent and permission.

_____ _____

Signature of patient or legal representative Date

IMPORTANT: If unable to obtain written consent from patient, please document when verbal consent was obtained. This will allow the ORENCIA RESPONSE PROGRAM® to continue with processing this enrolment.

_____ _____

Verbal consent obtained by Date

ORENCIA RESPONSE PROGRAM®
CONSENT AND PERMISSION

ORENCIA response Program®

Consent and permission

In order to register for the ORENCIA RESPONSE PROGRAM®, [a customer service program currently administered by Innomar Strategies Inc. ("Administrator") and sponsored by Bristol-Myers Squibb Canada ("BMS")], you and your healthcare professional will need to complete the information on the ORENCIA RESPONSE PROGRAM® Consent and Enrollment Form, and then fax, telephone, or mail in the information. This means that the program will be collecting some of your personal information, such as your name, age, address, telephone number, as well as medical and financial information as it affects your therapy administration and prescription reimbursement. For the ORENCIA RESPONSE PROGRAM® to provide you with the above services we may need to disclose some of your personal information. Nonpersonally identifiable, aggregate data may also be used for reporting purposes.

All personal information is stored in encrypted databases for electronic information and locked in filing cabinets within a restricted area for paper files. Only ORENCIA RESPONSE PROGRAM® personnel who require the information for the purpose of conducting program activities have access to the paper or electronic files. Patient files will be maintained for as long as the ORENCIA RESPONSE PROGRAM® is in operation and for three years after the completion of the program in order to meet legal requirements for maintaining patient records. Contact the ORENCIA RESPONSE PROGRAM® to speak with the privacy officer for more information or to address any additional questions you may have. Please read this entire form carefully before signing. It is your right to refuse to sign the consent form; however, if you do not provide consent you may not be eligible for the ORENCIA RESPONSE PROGRAM® services. If you have any questions, please feel free to contact the ORENCIA RESPONSE PROGRAM® for more information at 1-877-979-3200. Calls may be monitored and recorded for quality assurance purposes.

Patient consent

In addition, collection of adverse drug events enables BMS to monitor the safety of their medicines in order to continuously assess their benefit-risk profile, as well as to comply with local and worldwide laws and regulations. My personal information and details of any adverse drug event occurring while on treatment with a BMS product can be communicated to Innomar and disclosed to BMS Pharmacovigilance. _____(initials)

All the information provided to BMS will be stored in the corporate safety database located in the United States, and may be shared with its group companies and regulatory authorities as required by laws and regulations.

I also consent to BMS contacting my physician in case any further clarification regarding the adverse drug event is needed.

For the purposes of performing services under the ORENCIA RESPONSE PROGRAM®, I agree that the Administrator and their respective employees, and consultants may collect personal information about me, including personal health information (i.e., name, contact information, information about my medical condition and about my health insurance) either directly from me or from my healthcare provider(s) and/or health insurer(s), if any, and use, disclose in confidence only for the purposes as described above or as authorized or required by law. Healthcare providers and Innomar representatives are not authorized to share patient identifiable data with BMS. I am, however, aware that certain health information about me may be disclosed by Innomar to BMS in an anonymous or aggregated format, once all personally identifying information has been removed.

If at any time and for any reason BMS appoints a new Administrator to replace Innomar as the administrator of the ORENCIA RESPONSE PROGRAM®, I hereby give permission for the current Administrator to transfer my personal information and medical records to a new administrator designated by BMS, for the purpose of continuing my participation in the ORENCIA RESPONSE PROGRAM® in the same manner as required of the current Administrator as set forth above. I further consent to be contacted by additional third party providers for the purposes of customer satisfaction follow up surveys concerning the ORENCIA RESPONSE PROGRAM® services I received as well as the provision of additional services that may be offered to my as part of the ORENCIA RESPONSE PROGRAM®.

I may withdraw my consent for such contact at any time by providing my request in writing to the Administrator at the fax number 1-877-979-3200. I recognize that any such withdrawal of my consent may limit the ability of the Administrator to deliver the service of the ORENCIA RESPONSE PROGRAM®.

Please consult the prescribing information for complete dosage and administration instructions.