CELLTRION CONNECT™
PATIENT SUPPORT PROGRAM

SEND COMPLETED ENROLMENT FORM TO:

1-855-966-2223

support@celltrionconnect.ca

Question? 1-855-966-1648

Pr Remsima™ SC
Infliximab

The CELLTRION CONNECT™ Patient Support Program (the "Program") is sponsored and offered by Celltrion Healthcare Canada Limited ("Celltrion") through its third-party provider McKesson Canada Corporation ("Program Administrator"), to support patients who have been prescribed Remsima™ SC (infliximab) ("Support Services"). Information contained in this document is used by the Program to facilitate access to Remsima™ SC.

PATIENT INFORMATION

Name: _____ Date of birth: DD/MM/YYYY

Address: _____ Email: _____

Tel. (home): _____ Okay to leave message: Yes ☐ No ☐ Known allergies: Yes ☐ No ☐

Tel. (other): _____ Best time to be contacted: AM ☐ PM ☐ If yes, please specify: _____

☐ By checking this box, I accept that Program Administrator may communicate with me via electronic means, to provide me with information relating to the Program. I acknowledge that I may at any time opt-out from such communications by advising Program Administrator by email at support@celltrionconnect.ca.

Preferred language: English ☐ French ☐ Other ☐ Please specify: _____

DIAGNOSIS

☐ Adult with moderate to severe active rheumatoid arthritis (RA) ☐ Other: _____

Patient prescribed methotrexate? Yes ☐ No ☐

TUBERCULOSIS (TB) ASSESSMENT

TB test ☐ Not required ☐ Positive (+) Date: DD/MM/YYYY ☐ Negative (-) Date: DD/MM/YYYY

Chest x-ray ☐ Not required ☐ Completed results Date: DD/MM/YYYY

Shingles vaccine ☐ Required Brand: _____ # of doses: ____ **Pneumococcal vaccine** ☐ Required Brand: _____ # of doses: ____

Relevant medical history/notes: _____

PHYSICIAN INFORMATION

Name: _____

Address: _____

Tel (office): _____ Fax (office): _____

Email: _____

SPECIALTY PHARMACY

Do you have a preferred Pharmacy that you are working with? Yes ☐ No ☐

Name: _____

Address: _____

Tel. _____

PHYSICIAN PRESCRIBING SECTION FOR REMSIMA™ SC

DOSAGE AND ADMINISTRATION

SC induction with Remsima™ SC 120 mg at Week 0, followed by additional SC injections at 1, 2, 3 and 4 weeks after first injection, then once every 2 weeks, starting from Week 6

OR

IV induction with 3 mg/kg dose of IV infliximab at Weeks 0 and 2, followed by Remsima™ SC maintenance with the 120 mg dose once every 2 weeks, starting from Week 6

When switching from maintenance therapy of IV infliximab to Remsima™ SC, Remsima™ SC may be administered 8 weeks after the last infliximab IV infusion

Pr Remsima™ SC Infliximab

Requested start date: DD/MM/YYYY Please ☑ and complete the required information.

Drug: Remsima™ SC (infliximab subcutaneous)

☐ Autoinjector: _____ Dose: 120 mg SC

Frequency: ☐ Inject every 2 weeks Duration: _____

Refills: _____ Other: _____

For patients transitioning from IV infliximab to Remsima™ SC, indicate date of last infusion: DD/MM/YYYY

☐ **Dose induction required**

Drug: ☐ Remsima™ SC 120 mg OR ☐ Intravenous infliximab

Brand: _____

Patient weight: _____ Date of weight: DD/MM/YYYY

Dose (mg): Exact dose: _____ OR Exact # of vials: _____ 100 mg vials

Frequency/duration

SC induction weeks: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 **IV Induction weeks:** ☐ 0 ☐ 2

☐ Other dosing instructions: _____

PRE-MEDICATION ORDER Please ☑ desired pre-treatment medication(s) administered prior to infusion at clinic (indicate dose/route).

☐ No pre-meds required

Pre-medications		Administration
☐ Diphenhydramine (e.g., Benadryl*)	____ mg	☐ PO or ☐ IV 15-30 min prior to infusion (max 50 mg)
☐ Acetaminophen	____ mg	PO 15-30 min prior to infusion
☐ Hydrocortisone	____ mg	IV 15-30 min prior to infusion
☐ Dimenhydrinate (e.g., Gravol*)	____ mg	☐ PO or ☐ IV 15-30 min prior to infusion
☐ Methylprednisolone	____ mg	15-30 min prior to infusion
☐ Other (indicate):*	_____	

*Please provide patient with a prescription. Patient will need to bring other medication to infusion visit.

For infusion reaction management: follow the current recommended standard protocol.

My signature acknowledges that: I consent to Celltrion contacting me with respect to the enrolment of this patient as may be required to administer or deliver the Program or the Support Services, or in the event of an adverse drug event relating to Remsima™ SC. This prescription is the original prescription that will be sent to the pharmacy chosen by the patient.

I consent to the Program Administrator designated agent for the purposes of forwarding the prescription to the Program and to the pharmacy. I consent to the Program Administrator collecting, using and disclosing my information for the purpose of delivering the Support Services, or for contacting me to improve the quality of the Support Services offered under the Program. **Please see consent details on back.**

_____ Physician signature

_____ College license #

DD/MM/YYYY Date†

†Effective date. Order(s) expire one year from the date of signature.

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

PATIENT CONSENT

The CELLTRION CONNECT™ Patient Support Program (the "Program") is a patient support program provided by Celltrion to Canadian patients who have been prescribed Remsima™ SC. The Program services may include health/disease/product information, insurance reimbursement assistance, treatment services or financial assistance (the "Support Services"). A third-party service provider, McKesson Canada Corporation, is the administrator of the Program ("Program Administrator"). Its employees and/or agents handle your personal information, which is processed in accordance with privacy laws and Celltrion privacy/data protection standards, as may be designated from time to time by Celltrion.

I understand and consent to the following:

(1) that personnel of the Program Administrator ("Program Personnel") may contact me by any means (e.g., phone, fax, email, mail, etc.) for the purposes of administering the Support Services;

(2) that my personal health information may be collected, used and stored by the Program Administrator and by my healthcare providers involved in the delivery of the Support Services;

(3) that my personal information may be exchanged among Program Personnel, my healthcare providers, and my insurers and/or other payers, Celltrion and/or Celltrion's agents and service providers, such as information technology providers, for purposes consistent with the Program's administration and the Support Services; and

(4) that my healthcare providers and the Program Administrator may share my personal information with Celltrion as necessary for Celltrion to comply with its legal and regulatory obligations, including with respect to safety and adverse drug reporting.

I understand that the Program Administrator may also share de-identified information (i.e., where personal identifiers are removed) and aggregate data (combined with other data) with Celltrion to conduct analyses for commercial, market and scientific research/publication purposes to improve the Program, or as otherwise may be permitted by law.

I understand that the collection, use and disclosure of information contemplated herein may involve the transfer of the information in jurisdictions located outside of Canada (including in the United States), where local laws may require the disclosure of personal information to governmental authorities under circumstances that are different than those that apply in Canada. The reasonable contractual measures taken to protect my personal information while processed or handled by these third parties outside of my country of residence may be subject to foreign legal requirements, for example requirements to disclose personal information to government authorities in those countries.

I understand and agree that Celltrion has the right without notice to (1) make changes to the scope of Support Services offered; (2) make changes to the eligibility requirements for the Support Services; or (3) discontinue the Program or any of the Support Services.

If at any time Celltrion appoints a new program administrator, I will be notified of same and I hereby authorize Celltrion to transfer my personal information to the new program administrator for the purposes of continuing my participation in the Program.

I understand that I have the right to have access to or to correct my personal information held by Program Administrator by contacting McKesson Canada, located at 4705 Dobrin, Saint-Laurent, Quebec, H4R 2P7, and by telephone at: 1-855-966-1648.

I understand that I have the right at any time to withdraw my consent to the use of my personal information but if I do decide to do so, I will no longer be participating in the Program.

In signing this form, I consent to the above.

☐ In addition to the above consent, I agree to the Program Administrator contacting me by electronic or other means for the purposes of market research. I acknowledge that I may at any time opt-out from such communications by advising Program Administrator by email at: support@celltrionconnect.ca

Patient signature: _____ Date: DD/MM/YYYY _____

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