Enrollment and Consent Form

Simlandi (adalimumab), biosimilar to HUMIRA®

Please fax completed form to 1-888-331-3432 Mon-Fri 8 am to 8 pm (ET) Tel: 1-855-310-5102

I. PATIENT SECTION (Please PRINT)

II. First Name Last Name

III. Date of Birth DD MM YYYY

IV. # Street

City Province Postal Code

V. Preferred Phone: Alternate Phone or email:

VI. Best Time of Day to Contact (ET):

- ◯ Morning 8 am to 12 pm
- ◯ Evening 5 pm to 8 pm
- ◯ Afternoon 12 pm to 5 pm
- ◯ No preference

VII. Preferred language: ◯ English ◯ French

II. ENROLLING HEALTHCARE PROFESSIONAL INFORMATION

Person Enrolling (please check one)

- ◯ Physician
- ◯ Drug Access Navigator
- ◯ Patient
- ◯ Nurse
- ◯ Pharmacist
- ◯ Nurse Practitioner

First Name Last Name

Hospital/Clinic/Pharmacy

Office Phone Office Fax

Email

Signature

III. SERVICES (for additional services, see side 2)

- ◯ Shingrix Vaccine
- ◯ Blood Work
- ◯ Compassionate Use
- ◯ Nutrition Counseling
- ◯ Self-Injection Training Required

IV. MEDICAL INFORMATION

Chest X-ray required ◯ No ◯ Yes

Result

TB Test required ◯ No ◯ Yes

Result

If TB test positive, is patient receiving anti-TB treatment?

- ◯ No
- ◯ Yes, to be completed on DD MM YYYY

Has the patient ever suffered a severe allergic reaction? ◯ No ◯ Yes

Allergies:

MEDICATION HISTORY

Previous:

Medication/Biologic:

V. PRESCRIPTION

Select the format, diagnosis and dosage

- ◯ **Pre-filled Syringe** 40 mg/0.4 mL
- ◯ **Pre-filled Syringe** 80 mg/0.8 mL
- ◯ **Auto Injector** 40 mg/0.4 mL

- ◯ **Rheumatoid Arthritis** – 40 mg subcutaneous injection (SC) every other week.
- ◯ **Psoriatic Arthritis** – 40 mg SC every other week.
- ◯ **Ankylosing Spondylitis**– 40 mg SC every other week.
- ◯ **Adult Crohn's Disease** – 160 mg SC at Week 0, followed by 80 mg SC at Week 2. Maintenance dose regimen is 40 mg SC every other week beginning at Week 4.
- ◯ **Adult Ulcerative Colitis** – Induction dose is 160 mg SC at Week 0, followed by 80 mg SC at Week 2. Beginning at Week 4, continue with a dose of 40 mg SC every other week.
- ◯ **Hidradenitis Suppurativa** – Initial dose of 160 mg SC, followed by 80 mg SC two weeks later. The maintenance dose is 40 mg SC every week beginning four weeks after the initial dose.
- ◯ **Plaque Psoriasis** – Initial dose of 80 mg SC followed by 40 mg SC given every other week starting 1 week after the initial dose.
- ◯ **Adult Uveitis** – Initial dose of 80 mg SC, followed by 40 mg SC given every other week starting 1 week after the initial dose.
- ◯ **Pediatric Uveitis** – For patients 2 years of age and older, based on body weight. For weight > 30 kg the dosage is 40 mg SC every other week (only in patients who require the full 40 mg dose). Administered in combination with methotrexate.
- ◯ **Adolescent Hidradenitis Suppurativa** – For adolescent patients (12 to 17 years of age weighing ≥ 30 kg) the dose regimen is 80 mg SC at Week 0 followed by 40 mg SC every other week starting at Week 1.
- ◯ **Polyarticular Juvenile Idiopathic Arthritis**– For patients from 2 years of age, based on body weight. For weight > 30 kg, the dosage is 40 mg SC every other week (only in patients who require the full 40 mg dose).

DURATION OF TREATMENT (months)

◯ 3 ◯ 6 ◯ 12 Other

VI. PHYSICIAN CONSENT – REQUIRED ONLY FOR THE INITIAL PRESCRIPTION

By signing below I confirm that: (i) I am the prescribing physician for this patient; (ii) this constitutes an original prescription for this patient [if applicable] and I authorize the JAMP Care Program to forward to the patient's pharmacy of choice on my behalf; and (iii) subject to the patient's consent, I agree to be contacted by the Program with regard to this patient to assist in administering the Program and providing patient care.

Physician License Number

Physician Signature

PLEASE COMPLETE SIDE 2

Patient consent to the collection, use and disclosure of personal information

VII. ADDITIONAL LAB TESTS/SERVICES

- ◯ Quantiferone Gold (GRA) TB Test
- ◯ TDM
- ◯ TB Skin Test
- ◯ Fecal Calprotectin
- ◯ QuantON Cal Testing
- ◯ Other Vaccinations (available on demand; please specify)

VIII. PATIENT CONSENT

I have reviewed and agreed to the Patient Consent to the Collection, Use and Disclosure of Personal Information on this page.

Patient or Primary Next of Kin Signature

Date: DD MM YYYY

◯ **If unable to obtain written consent from patient or primary next of kin, please document verbal consent.**

Name of the person who obtained the verbal consent

Signature of the person who obtained the verbal consent

Relationship to patient

Date on which verbal consent was obtained

DD MM YYYY

(NOTE: The verbal consent option only applies to provinces outside of Alberta. Under Alberta law, verbal consent is not permitted.)

If you have questions regarding the program, please contact the JAMP Care Patient Support Program: 1-855-310-5102

The JAMPCare™ Patient Support Program is sponsored and offered by JAMP Pharma Corporation ("**JAMP**") in order to support patients who are taking certain JAMP products (the "**Program**"). The Program is administered by JAMP and a third-party service provider and their agents and affiliates (collectively, "**Program Administrators**").

In order to enrol you in the Program, you or your healthcare provider have provided the Program with certain information about you, as outlined on the Enrolment Form and the Program may collect other information from you or your healthcare provider including your personal information and personal health information (e.g., name, gender, age, address, telephone number, email, medical, financial and insurance information as it affects your therapy and prescription reimbursement) (collectively, your "**Information**").

The Program will collect, use, disclose and store your Information to provide you with the following services ("**Program Services**"), as required:

- Progress monitoring and reporting;
- Nursing and pharmacists' support;
- Assistance in communicating with drug plan administrators, managers or insurance companies to aid in securing reimbursement coverage for your prescription;
- Reporting on your insurance coverage to your physician;
- Opportunity to participate in market research involving people with your condition or educational initiatives in your area; and/or
- Regular communications on your therapy, devices (if applicable) and support program offerings.
- Nutrition Counseling
- Self-injection

By signing and submitting this form, you are consenting to the collection, use and disclosure of your Information by the Program Administrators for administration of the Program and the provision of Program Services and as required or permitted by law and in accordance with the Program's Privacy Policy, which can be obtained by calling 1-855-310-5102 or visiting www.jampcare-support.ca. You also understand that the Program Administrators may contact you in connection with administration of the Program and provision of Program Services, and you agree to be contacted now and in the future by the Program Administrators regarding the Program, your condition and/or your prescription.

In addition, you authorize the Program to obtain further information from your healthcare providers and health insurance company as deemed necessary to ensure the accuracy and completeness of your Information, to administer the Program, and/or to provide Program Services.

Use and disclosure of your Information

The Program will keep the Information that you provide confidential and will use it only for the purposes set out in this consent form. From time to time, the Program may need to disclose certain Information to a third party who is involved in delivering Program Services. This may include, for example, a dispensing pharmacist, reimbursement navigator, field nurse service, nutritionist or an insurer. The Program may also share the Information provided on this Enrolment Form for the purpose of obtaining patient support services from another program (e.g., if your pharmacy of choice does not carry the Jamp product you have been prescribed). The Program will limit the amount of Information disclosed to only that Information required in order to deliver the Program Services to you. The Program may de-identify your Information for use in reporting, publication and for promotional purposes. All Information collected and recorded in the Program will be treated and maintained by Program Administrators in compliance with applicable privacy and health privacy legislation. Your Information may be collected, used and disclosed and/or stored outside of your province/territory or country, and the privacy laws of those jurisdictions may be less-stringent than the laws of Canada and/or your home province/territory. Your Information will be maintained for as long as the Program is in operation and as may be required thereafter in order to meet legal requirements for maintaining patient records. For more information or to address any additional questions, please contact the Program to speak with the privacy officer. Calls may be monitored and recorded for quality assurance or training purposes.

You can withdraw your consent at any time. If you choose to withdraw consent to the Program, please be aware that you may be ineligible for Program Services, including patient support and reimbursement assistance, from the date of withdrawal.

You understand that JAMP may appoint a new Program Administrator at any time and you consent to the continued collection, use and disclosure of your information by the new Program Administrator as set out on this form.

You understand that any financial assistance provided to you as a result of your enrollment in the Program may be reportable income to public or private payers or government agencies. You understand that you are solely responsible for such reporting as well as for ensuring compliance with accepting any such financial assistance.

If you have any questions, please feel free to contact the Program for more information. To obtain information about the Program's privacy policies and procedures, please contact the Program's privacy officer at 1-855-310-5102 or visit www.jampcare-support.ca

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