Patient Enrolment, Rx & Consent Form

Tremfya® (guselkumab) | Tremfya® (guselkumab) One-Press™

PLEASE FAX TO YOUR JANSSEN BIOADVANCE® COORDINATOR UPON COMPLETION

Janssen BioAdvance® Coordinator:	Tel.:	Fax:

PATIENT INFORMATION

Gender: ☐ M ☐ F

Patient Name:	
Address:	
Tel. (Home):	Tel. (Other):
Can leave a message at this phone number? ☐ YES ☐ NO	
Email:	
Date of Birth:	Health Card #:

PHYSICIAN INFORMATION

Physician Name:	
Other Office Contact:	
Office Address:	
Email:	
Tel. (Office):	Fax (Office):

PRESCRIPTION INFORMATION†

Please ☑ and complete the required information.

INDICATION

☐ Plaque Psoriasis

☐ Psoriatic Arthritis

DOSAGE FORM

☐ **TREMFYA®** pre-filled syringe guselkumab injection DIN 02469758 100 mg/1 mL subcutaneous

☐ **TREMFYA ONE-PRESS™** patient-controlled injector guselkumab injection DIN 02487314 100 mg/1 mL subcutaneous

Other Directives / Notes:

DOSE

INITIAL weeks: ☐ 0 ☐ 4

AND/OR

MAINTENANCE Q 8 WEEKS: ☐ Repeats

REIMBURSEMENT

PSORIASIS ASSESSMENT DETAILS

BSA %:	PASI:	DLQI:

☐ Face ☐ Hands ☐ Feet ☐ Genitals

PSORIATIC ARTHRITIS ASSESSMENT

_____ # Swollen Joints

_____ DAS28 Score

_____ HAQ Score

☐ Radiographic Evidence of PsA

TUBERCULOSIS EVALUATION

☐ Pending

☐ Negative Result Date:

☐ Comments

PREVIOUS THERAPIES

PSORIASIS

		Start/stop dates/Comments:
☐ Methotrexate	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Acitretin	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Cyclosporine	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Topicals	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Phototherapy	☐ Failure ☐ Not Available ☐ Other	
☐ Other	☐ Intolerance ☐ Contraindication ☐ Failure	

PSORIATIC ARTHRITIS

		Start/stop dates/Comments:
☐ Methotrexate	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Leflunomide	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Sulfasalazine	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Other	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Other	☐ Failure ☐ Not Available ☐ Other	
☐ Other	☐ Intolerance ☐ Contraindication ☐ Failure	

PHYSICIAN

† 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.

Physician Signature:	College License #:	Date†:

PATIENT

I have read and understood the Patient Consent text printed on the back of this form and agree to the collection, use and disclosure of my personal information in accordance with these terms.

Patient Signature:	Date:

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BIOADVANCE® PERSONAL INFORMATION CONSENT AND PATIENT DISCLOSURE

The BioAdvance® patient support program (the "**Program**") is administered by independent BioAdvance Coordinators ("**BACs**") on behalf of Janssen Inc. ("**Janssen**"). The Program currently includes a support program for patients prescribed REMICADE®, STELARA®, SIMPONI®, TREMFYA®, DARZALEX®, IMBRUVICA®, ZYTIGA®, ERLEADA®, and EPREX® (and may be extended to other prescription medications manufactured and/or distributed by Janssen) ("**Medication**"), cost reimbursement assistance, therapy administration assistance and training, compliance and adherence and, with your consent, limited market research activities (for example, conducting surveys of your experiences with the Program).

You agree that the BAC assigned to managing your patient file may collect information from and share information with your healthcare providers, including your treating physician(s), nurse(s), pharmacist(s), healthcare providers at Program clinics or other facilities where you receive treatment (collectively the "**Healthcare Providers**") as well as other BACs and service providers retained by Janssen to provide essential services comprising the Program (such as financial assistance, insurance reimbursement or Medication access or management). They may do so as necessary to provide you with the essential services comprising the Program, or for other purposes with your consent or as permitted or required by law. You also agree that the service providers, in order to provide essential services comprising the Program, may collect information from and share information with your Healthcare Providers. You agree that the BACs, Healthcare Providers and other Program service providers may contact you for information required for the administration of the Program, by mail, email or phone at the addresses and number(s) provided. Personal information previously collected by Janssen may be disclosed to and used by the BACs and Healthcare Providers, for the above purposes. In the event that your Medication is part of a multiple therapy regime, the BACs and Healthcare Providers may share information with other drug manufacturers and their service providers as necessary to provide patient support for the necessary concomitant medications.

If at any time Janssen appoints a new entity to provide the services currently provided by the BACs, Janssen will provide you with notice and you agree that your personal information may be transferred to the new service provider for the purposes of continuing your participation in the Program.

The BACs, Healthcare Providers and other Program service providers may share your personal information with Janssen as necessary for Janssen to comply with its legal and regulatory obligations (including with respect to safety and adverse drug event reporting), for auditing purposes, and for other purposes with your consent. The BACs, Healthcare Providers and other Program service providers may share de-identified (your name and personal identifiers are removed) and aggregate data with Janssen for internal Program or Medication evaluation, future studies and scientific research, market research, regulatory purposes, safety and adverse drug event reporting, and otherwise as permitted or required by law. Such data, together with Your personal information, may also be used to improve Your particular Program experience and/or to enhance the level of support specifically provided to You.

The file containing Your personal information will be stored on secure servers, maintained by our service providers. Janssen and its service providers will collect, use, disclose and protect Your personal information as described above and otherwise in accordance with applicable privacy laws and their respective privacy policies, as applicable. Authorized employees, agents and mandataries of Janssen will have access to Your personal information as necessary to provide the Program. For more information about Janssen's privacy policy and practices, please submit a written request to Chief Privacy Officer, Janssen Inc. 19 Green Belt Drive, Toronto, ON M3C 1L9 or chiefprivacyofficer@its.jnj.com. You can request access to, or correction of, Your personal information, or withdraw Your consent at any time by contacting the BAC assigned to managing Your patient file or Janssen in writing at the addresses above. You understand that withdrawing Your consent will result in the termination of Your enrolment in the Program.

You understand that participation in the Program is voluntary and that if You choose not to participate, this will not impact Your medical treatment, insurance coverage or access to Medication. The Program is not intended to provide medical advice or medical diagnoses and You should always seek the advice of Your physician, pharmacist or other qualified health provider if You have any health concerns. Janssen reserves the right to change or terminate the Program at any time without notice.

I have read and understood this BioAdvance® Personal Information Consent and Patient Disclosure and agree to the collection, use and disclosure of my personal information in accordance with these terms.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Legal Representative

Legal Representative Relationship to Patient

I hereby attest that I have read this BioAdvance® Personal Information Consent and Patient Disclosure form in its entirety to the patient and that the patient has provided their consent to the collection, use and disclosure of their personal information in accordance with its terms.

Printed Name of Healthcare Provider Attesting

Signature of Healthcare Provider Attesting

Date

Please check the following boxes to indicate Your agreement, where applicable. You may refuse to provide Your consent to the following, and such refusal will have no impact on Your enrolment or participation in the Program:

☐ Janssen may send me educational materials and event invitations, unrelated to the administration of the Program, by way of email or mail at the addresses provided.

Janssen Inc. 19 Green Belt Drive | Toronto, ON | M3C 1L9 | www.janssen.com/canada