XPOSE® program enrollment and consent form:

For patients prescribed PrCOSENTYX® (secukinumab) for psoriatic arthritis or ankylosing spondylitis

Telephone: 1-844-27XPOSE (1-844-279-7673)
Fax: 1-866-872-5771

All sections MUST be completely filled out

Referring physician (please print or stamp)

First name _____ Last name _____

License # _____

Address _____ City _____ Province _____ Postal code _____

Office contact name _____

(____) ____ - ____ (____) ____ - ____

Telephone Fax

E-mail _____ I consent to receive e-mails related to the Program.

Preferred mode of communication: ☐ Phone ☐ E-mail ☐ Fax

Patient information (please print)

The XPOSE® program will contact you to assist with your insurance/reimbursement needs and provide you with information about the medication and your illness.

First name _____ Last name _____

Date of birth (mm/dd/yyyy) _____ ☐ Male ☐ Female

Address _____ City _____ Province _____ Postal code _____

(____) ____ - ____ (____) ____ - ____

Mobile phone Other

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening
Mode of communication: ☐ Phone ☐ E-mail ☐ Text message
Language: ☐ English ☐ French

E-mail _____ I consent to receive e-mails related to the Program.

☐ I agree to be contacted for market research purposes and studies.

Rx

COSENTYX® format: ☐ SensoReady® pen ☐ Pre-filled syringe

Psoriatic arthritis

New RX ☐ 150 mg sc ☐ 300 mg sc

Consider using the 300 mg dose for psoriatic arthritis patients with moderate to severe plaque psoriasis or who are anti-TNFα inadequate responders and who continue to have active psoriatic arthritis.

Renewal ☐ 150 mg sc ☐ 300 mg sc

Duration of treatment: _____ (months)

COSENTYX® is administered at weeks 0, 1, 2, 3 and 4 followed by monthly maintenance dosing.

PsA assessment details

HAQ: _____
CRP: _____
BASDAI: _____
DAS-28: _____
Radiographic evidence: _____
Swollen joint count: _____

Has the patient had previous biologic exposure?
☐ Yes ☐ No

If yes, please specify which one(s):
_____
_____
_____

Ankylosing spondylitis

New RX ☐ 150 mg sc

Renewal ☐ 150 mg sc

Duration of treatment: _____ (months)

COSENTYX® is administered at weeks 0, 1, 2, 3 and 4 followed by monthly maintenance dosing.

AS assessment details

BASDAI _____
BASFI: _____
HAQ: _____
Spinal pain VAS (cm): _____
Radiographic evidence: _____

Has the patient had previous biologic exposure?
☐ Yes ☐ No

If yes, please specify which one(s):
_____
_____

Tuberculosis (TB) screening

☐ Required ☐ Not required

Test results†

☐ Positive ☐ Negative

Do you require the Program to schedule TB testing on your behalf?

☐ Yes ☐ No

Chest X-Ray† (CXR)

☐ Required ☐ Not required

Test results†

☐ Positive ☐ Negative

Injection services

☐ Injection training required

Pharmacy services

☐ Innomar
☐ Other: _____
_____

Directives from the prescriber

I hereby confirm the prescription.

Please specify any further instructions (e.g., awaiting test results, washout period, rush start date):

_____
_____
_____

I certify that this prescription order is an original prescription. The designated pharmacy is the only recipient. The original will not be reused.

Therapy initiation

☐ Immediately
☐ Pending test results

Date (mm/dd/yyyy) _____

COSENTYX® NOW sample program

Number of doses provided ☐

Physician signature

I have read and agree to the physician declaration on the reverse side of this form.

X _____ _____

Physician signature Date (mm/dd/yyyy)

Patient signature

I have read and agree to the patient consent on the reverse side of this form.

X _____ _____

Patient signature Date (mm/dd/yyyy)

† Specific TB results will be reported back to the requester by the Program.
Any follow-up on positive TB is at the discretion/responsibility of the requester.

Cosentyx secukinumab XPOSE®

Recommended dose

1. **Psoriatic arthritis** ..... 150 mg sc
2. **Psoriatic arthritis patients with moderate to severe plaque psoriasis or who are anti-TNFα inadequate responders and who continue to have active psoriatic arthritis** ..... 300 mg sc

Recommended dose for ankylosing spondylitis ..... 150 mg sc

COSENTYX® is intended for use under the guidance of a health care professional. Patients may self-inject after proper training and when deemed appropriate. Prescribers are advised to periodically reassess the need for continued therapy.

Physician declaration

I have read the Patient Consent section of this form and confirm: (1) I agree to my patient being enrolled in the XPOSE® program ("Program"); (2) I have prescribed the drug specified on this form in accordance with its product monograph; and (3) I have the patient's express consent to provide the Program with the information in this form and any other information relevant to provide the Program's services.

I understand the information I provide to the Program may be shared with Novartis (as defined herein). My information may be used by Novartis for the following reasons, such as improving and auditing its programs, for marketing or market research purposes, or as otherwise permitted by law. Details about how my file will be maintained, and how to access/correct my information, are as set out in the Patient Consent section.

I acknowledge that adverse events may be reported about my patients who are participating in the Program during the course of their participation in the Program. I understand I may be contacted by Novartis or the Program Administrator to provide follow-up information relating to adverse events. Adverse event reports may need to be forwarded to regulatory authorities in and outside of Canada.

I have met with the patient, discussed the Program, patient is interested in enrolling and having more information and has consented to share his/her personal information for the Program Administrator to provide patient with information on the Program and confirm consent to enroll.

Patient consent

The XPOSE® program ("Program") is provided by Novartis Pharmaceuticals Canada Inc. and/or its affiliates (collectively "Novartis"), who may retain third parties to administer the Program or may administer the Program itself (in either case referred to as "Program Administrators"). The Program provides patient support services which may include, as applicable, insurance reimbursement assistance or product-related services. Novartis reserves the right to modify or terminate the Program at any time without prior notice.

Your participation in the Program is voluntary. If you choose not to participate, neither your medical treatment nor your insurance coverage eligibility will be impacted. However, if you do not participate, you cannot receive assistance from the Program.

By signing below, you agree that the Program Administrators can collect, use and disclose information about you, including your date of birth, contact information, drug/medical, and insurance/financial information (collectively "Personal Information"), to provide you with the Program's services, to monitor or audit the Program or as otherwise required or permitted by law, including for adverse event reporting obligations. Your Personal Information may be collected from and/or disclosed to your physician, nurse, pharmacist, insurance provider or others as necessary, and you authorize your health care professional to provide the Program Administrator with this completed form. You may be contacted by email, phone or otherwise using the contact information provided and you are responsible for any resulting cellular phone charges.

Novartis may receive de-identified data from the Program for publication or commercial purposes, but will not receive your personally identifiable information (unless it is the Program Administrator), except for adverse event purposes, to monitor or audit the Program, or if required or permitted by law.

The Program is not intended to provide medical advice or medical diagnoses. You agree to seek the advice of your physician or other qualified health care professional if you have health concerns, and not to disregard professional medical advice based on information obtained from the Program.

Personal Information may be stored or processed outside of Canada, where it may be subject to the laws of foreign jurisdictions. To access Novartis' privacy policy, please visit www.novartis.ca/en/privacy-policy.

You may revoke this consent at any time by calling the Program at 1-844-279-7673. Withdrawing your consent will result in the termination of your participation in the Program. The file containing your Personal Information will be maintained at the offices of the Program Administrator, where its authorized employees will have access to your Personal Information to administer the Program. You may request access to, or correction of, your Personal Information by contacting the Program in writing at privacy.pharmacanada@novartis.com or Privacy Officer, 385 Bouchard, Dorval, Québec, H9S 1A9.

COSENTYX® (secukinumab) is indicated for the treatment of:

- Adult patients with active psoriatic arthritis when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. COSENTYX® can be used alone or in combination with methotrexate
- Adult patients with active ankylosing spondylitis who have responded inadequately to conventional therapy

Consult the Product Monograph at www.novartis.ca/CosentyxMonograph for contraindications, warnings, precautions, adverse reactions, interactions, dosing, and conditions of clinical use. The Product Monograph is also available by calling 1-800-363-8883.

For program-related inquiries, please call the XPOSE® program at 1-844-27XPOSE (1-844-279-7673)

NOVARTIS

Novartis Pharmaceuticals Canada Inc.
Dorval, Québec H9S 1A9
www.novartis.ca
514.631.6775 514.631.1867

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Cosentyx secukinumab

XPOSE®