

XPOSE® program enrollment and consent form:

For patients prescribed PrCOSENTYX® (secukinumab) for moderate to severe plaque psoriasis

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 _____ Preferred mode of communication:
I consent to receive e-mails related to the Program. 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 _____

Male Female

Date of birth (mm/dd/yyyy) _____

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.

R_x

COSENTYX® format: **SensoReady® pen (2 x 150 mg)**
 Pre-filled syringe (2 x 150 mg)

Moderate to severe plaque psoriasis

New RX 300 mg sc

Renewal 300 mg sc

Duration of treatment: _____ (months)

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

Psoriasis assessment details

PASI: _____ BSA %: _____ DLQI: _____

Affected areas: _____

Previous treatment: _____

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.

Recommended dose for moderate to severe psoriasis: 300 mg (2 x 150 mg)

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 a third party to administer the Program or may administer the Program itself (in either case referred to as "Program Administrator"). 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 moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy.

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)



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