MyADvantage™ Support Program Enrolment Form

Fax completed form to 1-833-760-6923 or email to info@myadvantagesupport.ca. To avoid delays, please complete all fields.
For any inquiries, please contact the program at 1-833-729-6923.

myADvantage™ Support Program

1. Patient Information

First Name: _____ Last Name: _____

Date of birth (DD/MM/YY): _____ Health card number: _____

Address: _____ City/Province/Postal code: _____

Phone number: _____ Email: _____

Alternative contact name: _____ Alternative contact phone number: _____

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening ☐ Other: _____ Language preference: ☐ English ☐ French

☐ Consent for the Program to email ☐ Consent for the Program to leave voicemail

2. Patient Consent

I wish to participate in the MyADvantage Support Program as described by my treating physician and **I have read and fully understand the Patient Consent and Privacy Information on the reverse of this form** and agree to the collection, use, and disclosure of my personal information in accordance with those terms.

☐ I authorize the use of my anonymous records, any observations, and findings found during the course of this program for education, publication and/or presentation. All information taken from the program will be made anonymous. I recognize that I will not be compensated for participation in this program. I know that I may withdraw consent for my information to be included in the aggregated data at any time by emailing info@myadvantagesupport.ca.

☐ **Patient Signature**: _____ **Date**: (DD/MM/YY) _____
Patient or legal representative if patient is 12–17 years old

OR ☐ **Verbal consent obtained from the patient on** (DD/MM/YY) _____
Patient or legal representative if patient is 12–17 years old

3. Medical Information *Please complete all fields to avoid delays*

Test scores: BSA: _____ IGA: _____ EASI: _____ DLQI: _____

Patient has trialed **two or more medium-to-high potency topical corticosteroids**: ☐ Yes ☐ No

Patient has trialed **topical calcineurin inhibitor(s)**: ☐ Yes ☐ No

Patient has trialed **methotrexate**: ☐ Inadequate response ☐ Intolerant ☐ No ☐ Contraindicated

Patient has trialed **cyclosporine**: ☐ Inadequate response ☐ Intolerant ☐ No ☐ Contraindicated

Patient has trialed **dupilumab**: ☐ Inadequate response ☐ Intolerant ☐ No ☐ Contraindicated

Patient has trialed **phototherapy**: ☐ Inadequate response ☐ Intolerant ☐ No ☐ No access to phototherapy

Special site involvement? ☐ Yes ☐ No ☐ **Patient is medically cleared to start treatment**

Notes:

4. Prescription Information

Diagnosis: ☐ **Moderate-to-severe atopic dermatitis** ☐ Program to coordinate injection training in consultation with the patient

Initial Rx (16 weeks):

☐ **Adtralza®** (tralokinumab) **600 mg loading dose, followed by 300 mg every other week after**

Maintenance Rx (after 16 weeks):

☐ **Adtralza®** (tralokinumab) maintenance **300 mg every other week**

☐ **Adtralza®** (tralokinumab) maintenance **300 mg every 4 weeks**

Duration for refills: ☐ 4 months ☐ 6 months ☐ 12 months

☐ Other _____

5. Prescriber Information and Consent

This form constitutes a legal prescription for the above-mentioned patient. I authorize representatives of the MyADvantage™ Support Program ("the Program") to forward the prescription on my behalf to the pharmacy chosen by the patient. **I have read and fully understand the Physician Consent and Privacy Information on the reverse of this form** and agree to the collection, use, and disclosure of my personal information in accordance with those terms.

Prescriber Name: _____ **Prescriber Signature**: _____ **Date**: (DD/MM/YY) _____

License #: _____ Prescribing clinic name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____ Preferred contact name: _____

Preferred contact method: ☐ Phone: _____ ☐ Fax: _____ ☐ Email: _____

Patient Consent

The words "you" and "your" on this page refer to the patient. "The Program" refers to the MyADvantage™ Support Program, currently administered by NavieGo Patient Programs LTD (the "Program Administrator").

The Program is sponsored by LEO Pharma Inc. ("LEO Pharma") and overseen and administered by the Program Administrator. You understand that the Program is intended to assist in navigation of reimbursement options and facilitating ongoing reimbursement, provide financial support if applicable, and provide additional treatment-related services, such as injections and injection training, educational services, and adherence monitoring and treatment efficacy (collectively, the "Services").

You understand that any financial assistance provided to you as a result of your enrolment 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.

You understand that it is your right to refuse to sign this consent form, and that if you do not provide consent, you will not be provided with access to the Program.

You confirm that the information contained in this form is complete and accurate to the best of your knowledge. You acknowledge that LEO Pharma reserves the right to modify or terminate the Program at any time, including that it may change Program Administrators in which case your personal information that has been collected will be shared with the new Program Administrator.

By signing this form, you agree to enrol in the Program and authorize your information to be collected, used, and disclosed as described below. You consent to be contacted by representatives of the Program to receive the Program Services.

Drug Safety

LEO Pharma has a legal obligation to collect, monitor, and maintain records of product quality complaints, adverse events, and other safety experiences. If you experience an adverse event, or other safety experience, LEO Pharma and its representatives will retain your information for these purposes. Pseudonymized personal data pertaining to safety cases is only shared with Health Authorities when required, and the personal identifiers are limited in every case handling step. LEO Pharma may contact you or your healthcare provider to request further information about your adverse event or other safety experience.

Physician Consent

I consent to the use of my prescribing information by the Program and LEO Pharma for the purpose of administering and monitoring the Program.

I consent to be contacted by representatives of the Program and LEO Pharma Inc. about the patient, the product, the Program, and/or for any adverse events or other safety experiences experienced by the patient.

I give permission for LEO Pharma to view the MyADvantage™ de-identified patient enrollment status for, but not limited to, sales and marketing, and provide permission for this to be done retroactively.

I understand that LEO Pharma reserves the right to modify or terminate the Program at any time, including that it may change Program Administrators in which case your personal information that has been collected will be shared with the new Program Administrator.

Personal Information: Collection, Use, and Disclosure

For Patient Only

To participate in the Program, you may be asked to provide personal information to representatives of the Program including:

- Personal information (e.g., contact information or proof of Canadian citizenship/residency)
- Financial information (e.g., copies of your Canadian income tax return, paystubs, or income statements)
- Information related to insurance coverage (e.g., information necessary to maintain insurance coverage)
- Personal health information (e.g., patient outcome questionnaires)

This information will be collected, used, disclosed, and stored by the Program to provide the Services and to receive feedback about your experience with the Program and the Program Services for the purposes of improving the Program. This information may be shared with:

- LEO Pharma, the Program Administrator and/or their affiliates and third-party service providers
- Your public and private insurers
- Your healthcare provider(s), who may share your information with your insurers

You authorize the Program to obtain further information from your prescribing physician and health insurance company as deemed necessary to ensure the accuracy and completeness of your Information and to administer the Program, and that such further information may include personal information and/or personal health information.

For Patient and Physician

All personal information collected as part of the Program will be:

- Maintained in accordance with applicable legislation, regulations, and guidelines and in accordance with LEO Pharma's Privacy Statement. A copy of the Privacy Statement is available at www.leo-pharma.ca/Privacy-Statement.
- Protected by adequate physical, administrative, and technical safeguards against loss or theft, and against unauthorized consultation, communication, copying, use, or alteration. These safeguards will apply regardless of the format in which your information is stored
- Kept in a personally identifiable format only if needed for the purposes described below under Drug Safety

LEO Pharma may use your de-identified information for various purposes such as evidence generation, including monitoring, assessing, and improving the Program. Your information may be transferred, stored, and/or processed outside of your home province/territory and/or outside of Canada and the privacy laws of those jurisdictions may be less stringent than the laws of Canada and/or your home province/territory.

You can access or correct your personal information held by the Program Administrator at any time by contacting the Program at 1-833-729-6923.

If you have any questions regarding this consent form or other questions relating to the Program or Program Services, please call 1-833-729-6923.

Withdrawing Consent (applies to Patient and Physician)

You can revoke your consent to the above and withdraw from the Program at any time by calling 1-833-729-6923 or by email at info@myadvantagesupport.ca. You acknowledge that your withdrawal is not retroactive and, as such, any activities related to your personal information prior to your withdrawal to the Program will not be affected. Your personal information will be deleted and/or securely maintained in accordance with applicable legislation, regulations, guidelines, and LEO Pharma's Privacy Statement.

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myADvantage™ Support Program

Pr Adtralza® (tralokinumab)

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