Pr ILUMYA® tildrakizumab Injection 100 mg/mL

SUN Patient Support Program for PrILUMYA®

PSP Contact Information:
Phone: 1-844-561-1259
Fax: 1-833-734-0617
Email: ilumya@bayshore.ca

Enrolment Form and Consent Form

Please complete and fax this Enrolment Form to **1-833-734-0617** or email to **ilumya@bayshore.ca**.
Please complete all fields to minimize delays. ☐ Reimbursement Support ☐ Injection Services ☐ Quantiferon TB Testing Service

SECTION 1: PATIENT INFORMATION

Patient First Name | Patient Last Name

Date of Birth (DD/MM/YYYY) | Legal Guardian Name (if applicable)

Gender ☐ Male ☐ Female Other | Language ☐ English ☐ French* Other

Patient Home Address

Email Address

City | Province | Postal Code

Phone Number | Alternative Phone

By adding your phone number(s), you agree and hereby authorize the program administrator to leave a voicemail or a text message, which may include personal information and personal health information

Best time to be reached ☐ Morning ☐ Afternoon ☐ Evening

SECTION 2: PRESCRIBER INFORMATION

First Name | Last Name

License Number

Street Address

City | Province | Postal Code

Office Phone Number | Office Fax Number | Mobile Phone Number

CLINIC CONTACT

Name _____

Email Address _____

Preferred Method of Communication
☐ Email ☐ Fax ☐ Mobile Phone ☐ Office Phone

* Je préfère utiliser la version anglaise de ce formulaire.

SECTION 3: CLINICAL INFORMATION

INDICATION
☐ Adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy
☐ Other (please specify)

TUBERCULOSIS (TB) ASSESSMENT
☐ Completed Date (DD/MM/YYYY) ____ / ____ / ____
☐ Not Completed
☐ Not Required
☐ Request Quantiferon Test

PSORIASIS ASSESSMENT DETAILS (please complete if necessary)

BSA %	PASI	DLQI	☐ Face ☐ Hands ☐ Feet ☐ Genitals ☐ Other (please specify)

PREVIOUS TREATMENT Select all that apply:
☐ Cyclosporine ____
☐ Topicals ____
☐ Methotrexate ____
☐ Acitretin ____
☐ Biologic ____
☐ Phototherapy ____

Other (please specify)/notes:

INJECTION STATUS
☐ Patient received their ILUMYA® injection in my office
☐ Patient will receive their ILUMYA® injection in my office
☐ Patient did not receive their ILUMYA® injection; request training

Patient is medically cleared to start therapy ☐ Yes ☐ No ☐ Pending Negative TB Test

Prescription
ILUMYA® (tildrakizumab injection)
Recommended dose: ILUMYA® 100 mg/mL Pre-filled Syringe (PFS), for SC injection on week 0, week 4, then every 12 weeks thereafter
☐ Dispense 3 units
Maintenance dose: Once every 12 weeks

Units to dispense _____

If using other dosing regimen, please specify: Dosing frequency _____ Units to dispense _____

SECTION 4: PHYSICIAN CONFIRMATION AND PATIENT CONSENT

PHYSICIAN

Prescriber Signature

_____

Date
(DD/MM/YYYY) _____

PATIENT

I have read, or it has been read to me, this form including the "Patient Declaration and Consent" appearing on the back. I understand all the terms and conditions stated herein, including those applicable to how my personal information will be collected, used, disclosed, and stored for the purposes of the patient support program. I confirm that I had the opportunity to ask all questions I wanted and that I had my questions properly answered. I agree to the terms and conditions for enrolment in the patient support program. I authorize the collection, use, storage, and disclosure of my personal information as described in this document.

Patient Signature _____

Date (DD/MM/YYYY) _____ **Patient Verbal Consent:** ☐ Yes ☐ No

Additional Comments _____

☐ Name of an authorized representative/legal guardian who may provide and sign this enrolment form on behalf of my patient

Patient Declaration and Consent

Collection and Use of Personal Information

The SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator and, as applicable, any third parties involved in the administration of the Program (the "Third Parties") may collect personal information about you, including your name, date of birth, address, phone number, email address, insurance coverage, and personal information about your health, such as information about your medical condition, treatment(s), and name of your healthcare providers. This information may be collected either directly from you, or from your authorized representative, your healthcare provider, or from your health benefit insurer. Your personal information may be used and stored by the SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator and, as applicable, the Third Parties, for the purposes of administering the SUN PATIENT SUPPORT PROGRAM for ILUMYA®, including performing SUN PATIENT SUPPORT PROGRAM for ILUMYA® effectiveness evaluation surveys and for SUN PATIENT SUPPORT PROGRAM for ILUMYA® monitoring and auditing purposes. The SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator and, as applicable, the Third Parties, may disclose your personal information to certain Third Parties involved in the SUN PATIENT SUPPORT PROGRAM for ILUMYA®, such as the Third Parties prescribing physician(s), pharmacist(s), private insurance company(ies), public payer(s), and any other healthcare provider or payer, within the limits required for these Third Parties to provide their services and functions under the SUN PATIENT SUPPORT PROGRAM for ILUMYA®. The SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator and, as applicable, the Third Parties, may also disclose your personal information to Sun Pharma Canada Inc. should you experience reimbursement issues or should an intervention by Sun Pharma Canada Inc. medical department be required in order to ensure proper administration of the SUN PATIENT SUPPORT PROGRAM for ILUMYA®. Sun Pharma Canada Inc. may also receive coded and aggregated information about your enrolment in the SUN PATIENT SUPPORT PROGRAM for ILUMYA® for reporting purposes, but this information does not allow identifying you.

Your personal information may also be held, used, and disclosed to comply with applicable laws, including for reporting adverse drug health events to Health Canada. Sun Pharma Canada Inc. may collect details of any adverse health event you may experience while using a Sun Pharma Canada Inc. product. Typically, these details will not disclose information which may readily identify you, but may include identifiers (your initials, date of birth or age, height, weight and gender) and information about the adverse event you may have experienced. You may also be asked to allow Sun Pharma Canada Inc. to contact you or your healthcare provider(s) in case any further clarification regarding the adverse drug event is needed. Any adverse drug event information provided to Sun Pharma Canada Inc. will be stored for the period of time required by law and may be shared with Sun Pharma Canada Inc. and regulatory authorities as required by applicable law.

Neither the SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator, any of the Third Parties, nor Sun Pharma Canada Inc. will sell your name or other personal information, or use or disclose your personal information for purposes other than what it was collected for or as otherwise identified in this document, unless required or permitted by law.

Patient Contact

While enrolled in the SUN PATIENT SUPPORT PROGRAM for ILUMYA® , you will be contacted by representatives of the SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator to administer SUN PATIENT SUPPORT PROGRAM for ILUMYA® services. You may also be contacted by any of the Third Parties for the purpose of evaluating the effectiveness of the SUN PATIENT SUPPORT PROGRAM for ILUMYA® and your contact details may be provided to such third parties for this purpose.

Personal Information Transfer and Storage

All personal information collected as part of the SUN PATIENT SUPPORT PROGRAM for ILUMYA® will be maintained in accordance with applicable legislation, regulations, and guidelines and in accordance with Sun Pharma Canada Inc. Privacy Statement, if applicable. The personal information collected is 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). The information is kept in a personally identifiable format only as long as needed for the purposes described above.

Your personal information may be held and used in, and transferred to, any province or country worldwide, including in the United States. In such a case, Sun Pharma Canada Inc. will obtain adequate contractual representations to the effect that your personal information will be protected by measures of at least the same level of protection as under Canadian applicable laws.

In addition, if at any time and for any reason Sun Pharma Canada Inc. appoints a new program administrator to replace the existing SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator, you hereby consent to the transfer of your personal information by the existing administrator to another third-party administrator for the purpose of continuing your participation in the SUN PATIENT SUPPORT PROGRAM for ILUMYA®. In such a case, Sun Pharma Canada Inc. will obtain adequate contractual representations to the effect that your personal information will be protected by measures of at least the same level of protection as currently provided.

Withdrawing from Program / Correcting Information

By enrolling in the SUN PATIENT SUPPORT PROGRAM for ILUMYA®, you hereby consent to these terms and conditions. You may at any time obtain a copy of your personal information from the SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator and Sun Pharma Canada Inc., if applicable, and can correct any errors and/or ask any questions regarding the collection, use, disclosure, and storage of your personal information by writing to Bayshore Healthcare, the SUN PATIENT SUPPORT PROGRAM for ILUMYA® administrator, at the following address or fax number:

2101 Hadwen Road, Mississauga, Ontario L5K 2L3
Tel: 1-844-561-1259 Fax: 1-833-734-0617

Program Hours 8am–8pm EST Business Days

Withdrawing your consent will end further uses and disclosures of your personal information (although it is not retroactive). Since your personal information is needed to administer the SUN PATIENT SUPPORT PROGRAM for ILUMYA®, if you withdraw your consent, your enrolment in the SUN PATIENT SUPPORT PROGRAM for ILUMYA® will end.

SUN DERMATOLOGY

Pr ILUMYA®
tildrakizumab
Injection 100 mg/mL