GPS GALDERMA PATIENT SERVICES

nemluvio® nemolizumab for injection

Enrolment Form

Scan or contact us for questions and support:
support@galdermagps.ca
1-833-338-0524

■ To be filled by the patient (or their legal guardian)
■ To be filled by the prescribing physician

Send completed form by either:
Fax: **1-888-388-8861** or Email: **support@galdermagps.ca**

Reset Form

Patient Information

Last name	First name	
Date of birth (yyyy/mm/dd)	Gender: ☐ Male ☐ Female ☐ Other: _____	
Health card number		
Address		
City	Province	Postal code
Patient/legal guardian's preferred method of contact: ☐ Phone ☐ SMS ☐ Email		
Mobile phone number	Alternate number	Leave messages: ☐ Y ☐ N
Email address		Preferred language: ☐ EN ☐ FR

Patient Direction and Consent

I hereby agree to be enrolled in the Galderma Patient Services Program (the "**Program**").

I hereby request that the Program Administrator provide my prescription to my designated pharmacy and I appoint the Program Administrator as my agent or mandatary to perform acts necessary to have my prescription filled by my designated pharmacy.

I understand and consent to the handling of my personal information as described in the Privacy Consent on the reverse side of this Enrolment Form and the Galderma Privacy Notice, available at www.galderma.com/your-data/privacy-notice-canada-EN.

☐ I consent to the receipt of electronic communications (e.g., emails and texts) from the Program Administrator and Program Personnel for the purpose of determining my eligibility to participate in the Program and conducting Program-related activities, including the delivery of Program services and updates. I understand that I can withdraw my consent at any time by following the instructions in the electronic communication or by contacting the Program Administrator at 1-833-338-0524 or by emailing support@galdermagps.ca.

Signature of patient or authorized representative	**Date (yyyy/mm/dd)**
Patient/legal representative name	
Legal representative relationship to patient	
☐ **Patient consented verbally** Name of healthcare professional obtaining verbal consent:	
Date verbal consent obtained (yyyy/mm/dd)	**Signature**

Prescribing Physician Information

Name		
Address		
City	Province	Postal code
Office phone	Office fax	
Email	Clinic contact (if not physician)	

Medical Information *(Please complete fields as needed for reimbursement request)*

☐ **Moderate-to-severe PN**	☐ **Moderate-to-severe AD**
Assessment Scores: PP-NRS: _____ DLQI: _____ IGA: _____ # of nodular lesions: ☐ ≥20 Duration of PN: ☐ ≥6 weeks	Assessment Scores: IGA: _____ EASI: _____ BSA %: _____ PP-NRS: _____ DLQI/CDLQI: _____ Special site involvement: ☐ Yes ☐ No

AD/PN Treatment History

☐ **TCS(s) (medium-to-ultra high potency):** _____
☐ Intolerance ☐ Inadequate response ☐ Contraindication

☐ **TCI(s):** _____
☐ Intolerance ☐ Inadequate response ☐ Contraindication

☐ **Cyclosporine** ☐ Intolerance ☐ Inadequate response ☐ Contraindication

☐ **Methotrexate** ☐ Intolerance ☐ Inadequate response ☐ Contraindication

☐ **Mycophenolate mofetil** ☐ Intolerance ☐ Inadequate response ☐ Contraindication

☐ **Azathioprine** ☐ Intolerance ☐ Inadequate response ☐ Contraindication

☐ **Biologic(s):** _____
☐ Intolerance ☐ Inadequate response ☐ Contraindication

☐ **JAKi(s):** _____
☐ Intolerance ☐ Inadequate response ☐ Contraindication

☐ **Phototherapy** ☐ Yes: ____ times per week for ____ weeks ☐ Not accessible

Notes:

Prescription: Nemolizumab for s.c. injection, pre-filled pen, 30 mg

Prurigo Nodularis (PN)	**Atopic Dermatitis (AD)**
☐ Loading dose: 60 mg at Week 0, followed by: ☐ <90 kg: 30 mg Q4W ☐ ≥90 kg: 60 mg Q4W Duration for refills: _____ months	☐ Loading dose: 60 mg at Week 0, followed by: ☐ 30 mg Q4W ☐ 30 mg Q8W (Week 16+) NEMLUVIO is given Q4W. For patients who have achieved a clinical response after 16 weeks, the recommended maintenance dose is 30 mg Q8W. Duration for refills: _____ months ☐ Initiate TCS/TCI with nemolizumab Specify: _____

☐ **Patient is medically cleared to start treatment**
Additional instructions/stamp:

Designated pharmacy: ☐ Program Administrator's pharmacy
☐ Other (please specify): _____

Injection training is arranged by the Program and is available to all patients.

Physician Acknowledgement and Prescription

This prescription represents an original of the prescription drug order. I authorize the Program Administrator to forward this prescription, by fax or electronically, to the pharmacy chosen by the patient as indicated above.

I consent to the collection, use and sharing of prescription information, including my name and professional credentials, with Galderma Canada Inc. and the Program Administrator, for the purposes of improving and auditing its programs as well as market research and analytics. I understand that I may withdraw my consent at any time by contacting the Program Administrator. I understand that the Galderma Privacy Notice, available at www.galderma.com/your-data/privacy-notice-canada-EN, provides more information about how my information is handled and my privacy rights and choices.

By providing my email address, I agree to receive, electronically, information and updates relating to my patient's enrolment in the NEMLUVIO® Patient Support Program. These communications will be provided by a third-party patient support program provider and its affiliates ("Program Administrator") acting on behalf of Galderma Canada Inc.

Physician signature	
License #	**Date (yyyy/mm/dd)**

AD=atopic dermatitis; BSA=body surface area; b.w.=body weight; CDLQI=Children's Dermatology Life Quality Index; DLQI=Dermatology Life Quality Index; EASI=Eczema Area and Severity Index; IGA=Investigator Global Assessment; JAKi=Janus kinase inhibitor; PN=prurigo nodularis; PP-NRS=Peak Pruritus Numerical Rating Scale; s.c.=subcutaneous; TCI=topical calcineurin inhibitor; TCS=topical corticosteroid.

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Patient Consent and Privacy Notice

A third-party patient support program provider and its affiliates (the "Program Administrator") will handle your personal information ("PI") on behalf of Galderma Canada Inc. ("Galderma") ("we", "us", "our").

Types of Personal Information. Your PI includes contact and background information (name, address, phone number, date of birth/age, sex, etc.), financial information (as it relates to any request under the program), and health information (medical history, medical condition(s), information relating to your treatment, and information relating to your health insurance coverage). It can also include any other PI you choose to provide us.

Purposes. We handle your PI to administer and improve the Program and its Services. This includes (1) communicating with you, (2) monitoring product complaints, reporting adverse events, and complying with legal obligations, (3) providing healthcare professionals' support, (4) working with drug plan administrators, managers and insurance companies to aid in securing reimbursement coverage for your prescription; (5) reporting on your insurance coverage to your healthcare professionals; and (6) counselling. We may also aggregate, de-identify, combine, and/or anonymize your PI along with other patients' PI for reporting and data analytics, which we use to monitor the Program and better understand and improve the Program and Services, including for research aimed at improving healthcare services and outcomes, and to generate reports that may be shared with Galderma.

Sharing and transfers. To achieve these purposes, your PI may be obtained from, or shared with, the Program Administrator, Galderma, and third parties including insurance providers, healthcare professionals, regulators, and drug plan administrators. If Galderma appoints a new program administrator, your PI may be transferred to such program administrator to ensure continuity of program Services. Your PI may be transferred, stored, or otherwise handled outside of your jurisdiction, and may be subject to the laws of that jurisdiction.

Further information. For more information about how your PI is handled and protected, as well as your privacy rights and choices, you can review the Galderma Privacy Notice, available at www.galderma.com/your-data/privacy-notice-canada-EN. If you wish to make inquiries, or have other privacy-related requests or concerns, you may contact Program Administrator in writing at support@galdermagps.ca.

For more information, please refer to the NEMLUVIO Product Monograph.

For medical information queries, please contact us at 905-762-2500 or medinfo.canada@galderma.com.
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GALDERMA
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