Pfizer Liaison
Patient Support Program

ENROLMENT AND CONSENT FORM

PLEASE SEND COMPLETED FORM BY EMAIL: pfizerliaison@bayshore.ca OR BY FAX: 1-844-636-6888

FOR MORE INFORMATION, PLEASE CALL TOLL-FREE: 1-844-616-6888

PATIENT CONSENT

NOTE **ENSURE THE PATIENT OR THEIR LEGAL REPRESENTATIVE HAS READ AND SIGNED THE PATIENT CONSENT STATEMENT ON THE REVERSE.**

PATIENT INFORMATION

Last name: _____

First name: _____

Date of birth: _____

Gender: ☐ Male ☐ Female ☐ _____

Hospital ID# (optional): _____

Address: _____

City: _____ Province: _____

Postal code: _____ Preferred language: _____

Phone number: Home: _____

Work: _____ Cell: _____

Best time to contact me on weekdays: _____

☐ Consent to leave message

Email (optional):* _____

* By providing your electronic address, you consent to receiving electronic communications containing information and updates relating to the Pfizer Liaison Patient Support Program (the Program), your health condition(s), your treatment(s), Pfizer's projects, or other related subjects. The company that runs the Program, Bayshore HealthCare Ltd. and its affiliates (Bayshore), is seeking your consent on behalf of Pfizer Canada (PC), the sponsor of the Program. You can withdraw your consent to receive electronic communications by following the instructions provided in the electronic communication. You can contact Bayshore at any time by calling toll-free 1-844-616-6888 or writing to them: Bayshore HealthCare Ltd., 2101 Hadwen Road, Mississauga, ON L5K 2L3.

Have you applied for provincial public insurance coverage?
☐ Yes ☐ No ☐ Unsure

Date of application: _____

Are you, or is someone in your household, currently covered by a private drug insurance plan? ☐ Yes ☐ No ☐ Unsure

Name of insurance company: _____

Date of application: _____

PHARMACIST INFORMATION

Pharmacist name and contact information: _____

DRUG ACCESS NAVIGATOR INFORMATION (if applicable)

Drug access navigator name and contact information: _____

PHYSICIAN INFORMATION

Physician name: _____

License number: _____

Affiliation: _____

Address: _____

Phone number: _____ Fax number: _____

Email:* _____

Other key contact person: _____

PHYSICIAN CONSENT STATEMENT

My signature acknowledges that:

- I am the patient's attending physician.
- I consent to be contacted for inquiries relating to my patient.
- I consent to Bayshore and PC receiving, collecting, storing, using, and disclosing any of my information that I have provided in respect to the patient that is necessary to assist the patient in obtaining any services or assistance the patient has authorized or consented to.
- I agree to allow Bayshore or PC to contact me for any other information regarding the Program that would result in enhancing the delivery or the quality of services offered by this Program to my patient.

I confirm that:

- The patient has been prescribed BESPONSA® (inotuzumab ozogamicin for injection), BOSULIF® (bosutinib), BRAFTOVI® (encorafenib), IBRANCE® (palbociclib), INLYTA® (axitinib), LORBRENA® (lorlatinib), MEKTOVI® (binimetinib), MYLOTARG® (gemtuzumab ozogamicin for injection), NIVESTYM™ (filgrastim injection), NYVEPRIA™ (pegfilgrastim), RUXIENCE® (rituximab for injection), SUTENT® (sunitinib malate), TORISEL® (temsirolimus concentrate for injection), TRAZIMERA® (trastuzumab), XALKORI® (crizotinib), or ZIRABEV® (bevacizumab for injection) by me as per the authorized indication.

SIGN HERE

_____ _____

SIGNATURE OF PHYSICIAN Date

☐ Physician has consented to be included in the Pfizer Liaison Registration of Physician Consent.*

* The Registration of Physician Consent is a one-time physician signature consent for future patient enrolments into the program. Contact pfizerliaison@bayshore.ca to receive details about this option.

TREATMENT INFORMATION

Patient cleared to start treatment: ☐ Yes ☐ No

Bridging medication required: ☐ Yes ☐ No

☐ **PrBESPONSA® (inotuzumab ozogamicin for injection)**
☐ **PrBOSULIF® (bosutinib)**
☐ **PrBRAFTOVI® (encorafenib)**
☐ **PrIBRANCE® (palbociclib)**
☐ **PrINLYTA® (axitinib)**
☐ **PrLORBRENA® (lorlatinib)**
☐ **PrMEKTOVI® (binimetinib)**
☐ **PrMYLOTARG® (gemtuzumab ozogamicin for injection)**
☐ **PrNIVESTYM™ (filgrastim injection)**
☐ **PrNYVEPRIA™ (pegfilgrastim)**
☐ **PrRUXIENCE™ (rituximab for injection)**
☐ **PrSUTENT® (sunitinib malate)**
☐ **PrTORISEL® (temsirolimus concentrate for injection)**
☐ **PrTRAZIMERA® (trastuzumab)**
☐ **PrXALKORI® (crizotinib)**
☐ **PrZIRABEV® (bevacizumab for injection)**

Indication: _____

Dosage: _____ Frequency: _____

Quantity: _____ Repeat: _____

Directions: _____

☐ Other product: _____

SIGN HERE

_____ _____

SIGNATURE OF PHYSICIAN Date

PATIENT CONSENT STATEMENT

By submitting my Personal Information (PI), I grant my full consent to allow Pfizer Canada (PC) and Bayshore HealthCare Ltd. and its affiliates to collect, use, access, and share my PI as described below. In order to assist with my enrolment in the Program, I confirm the background information I have provided is accurate and complete, and that Bayshore may use the information that I have provided to contact me about the Pfizer Liaison Patient Support Program (the Program).

Your PI includes your individual information (name, address, phone number, date of birth, etc.), your financial information, and your health information (medical history, medical condition(s), information relating to your treatment, and information relating to your health insurance coverage, etc.).

PC (Program sponsor and manufacturer of the Medication) and Bayshore (the administrator of the Program on behalf of PC) are asking for your permission to collect, use, and share your PI in order for you to participate in this Program.

In order for me to take part in the Program, and for PC and Bayshore to carry out the Program activities for me, I:

- Allow my healthcare provider, health insurer, PC, and Bayshore to collect, use, access, share with each other, and store my PI;
- Authorize Bayshore to investigate and determine on my behalf, or that of my dependent, any and all information related to my insurance coverage (group health drug plan, private medical insurance, and government drug benefit plans) and its conditions, as it relates to medications or other medical benefits associated with my medical treatment, to determine my eligibility for reimbursement assistance. I acknowledge that in investigating my full benefit potential, Bayshore will need to contact my insurer or my physician for additional information;
- Allow PC to collect my PI and information on my use of the Medication and any unwanted drug effects ("adverse drug events" or side effects) that I may experience while taking the Medication or other medications made by PC and provide this information to Health Canada or other government agencies. PC and Health Canada ask for this information to track the safety record of these medications. PC may also contact Bayshore or my healthcare provider if they need more information on the adverse drug event(s);
- Allow PC or Bayshore to contact me about my PI or any other information or documentation needed or related to the Program or to my medical condition(s) and treatment(s). PC may use this information to better understand and improve its products and programs. PC and Bayshore may ask for my feedback on the quality of the services offered by the Program, advise me of Program improvements, ask about my progress while taking the Medication, and conduct other limited market research;
- Allow PC and Bayshore to transfer my PI to an affiliate or to a third-party service provider that will process or store my PI (on behalf of PC/ Bayshore) for purposes relating to the administration of the Program;
- Allow PC to collect, share, and publish anonymized statistical data with healthcare providers and third parties for reimbursement, publication, or commercial purposes;
- Will not seek to have the amount of support I receive by way of this Program counted in any government drug plan out-of-pocket expenses for prescription drugs; and
- Acknowledge the benefits of the Program that are available to me may change, including financial assistance for the cost of medication. In the future, my contribution to the costs of my medication may increase depending on my insurance plan.

You agree that, if Bayshore discontinues some or all of its involvement with the Program, your PI may be provided to a new program administrator appointed by PC to administer the Program, and you consent to the collection, use, storage, and disclosure of your PI by the new program administrator as described in this form.

PC and Bayshore are committed to respecting your privacy. The PI collected from you on this form and during your enrolment in this Program will be maintained in strict confidence and will not be disclosed to third parties, other than to those engaged to fulfill the above purposes or as permitted or required by law. Your PI may also be disclosed and/or transferred to an affiliate of PC or Bayshore, or to a third party, in the event of a proposed or actual purchase, sale, lease, merger, amalgamation, or any other type of acquisition, disposal, transfer, conveyance, or financing of PC or a division thereof. Your PI may be transferred to an affiliate of PC or Bayshore, or a service provider of PC or Bayshore for processing or storage outside of your province, territory, or country and would become subject to the laws of the country where it is stored/processed. The laws of other countries regarding privacy may be less strict than the laws of Canada and its provinces.

If you later change your mind about such collection, use, access, and disclosure for any reason, you may withdraw your consent by calling Bayshore toll-free at 1-844-616-6888 or by writing to them at: Bayshore HealthCare Ltd., 2101 Hadwen Road, Mississauga, ON L5K 2L3. You understand that withdrawing your consent may result in the termination of your enrolment in the Program and you may no longer receive support services relating to the Medication. Unless consent is withdrawn, your consent is valid for as long as you receive services from the Program and for a reasonable time thereafter.

You have a right to access and correct your information, where required. Any inquiry concerning your PI should be addressed to Bayshore using the above contact information.

PC reserves the right to modify or terminate the Program at any time without prior notice.

PATIENT CONSENT

I have read, understand, and agree to the patient consent statement above.

SIGN HERE

X _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

Date: _____

Printed name of legal representative: _____ Relationship of legal representative to patient: _____

☐ Verbal consent obtained

SIGN HERE

X _____

BY WHOM

Date: _____

☐ I grant Pfizer Liaison, or its representatives, permission to speak to a family member on my behalf.

Name: _____ Phone number: _____ Relationship: _____

Program administered by Bayshore HealthCare Ltd.
Financial assistance cannot be guaranteed.

MEMBER OF INNOVATIVE MEDICINES CANADA

REVIEWED BY PAAB

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