GLENMARK CANADA APREMALIST

PATIENT PSP ENROLMENT CONSENT, and Rx FORM

PHN/FAX: 1-833-500-0178 **Email:** glnapremilast@psphelp.ca

Patient First Name	**Patient Last Name**		
Address	**City**	**Province**	**Postal Code**
Email	**Mobile Phone**	**Alt. Phone**	**Ok to leave VM?** Yes☐ No☐
Date of birth (DD/MMM/YYYY)	**Health Card Number (if applicable)**		

Prescriber Name	**Prescriber Last Name**	**Prescriber Email**	
Address	**City**	**Province**	**Postal Code**
Phone		**Fax**	
Special instructions:			
Private coverage: Yes ☐ No ☐ | **Public coverage**: Yes ☐ No ☐ **Special Authorization:** Yes ☐ No ☐ | **Has SA been submitted:** Yes ☐ No ☐ | **Submission date:** _____			
Medically cleared to start: Yes ☐ No ☐ | **Bridging required**: Yes ☐ No ☐			

Psoriatic Arthritis ☐ Plaque Psoriasis ☐ Bechet's ☐ Other ☐ : _____

APREMALIST Starter Pack: Take as directed for 14 days X 27 tablets ☐ **:** _____

APREMALIST Maintenance dose: 30mg PO BID ☐ **:** _____

Duration: ☐ 3 months, ☐ 6 months, ☐ 12 months, Other ☐ : _____

Prescribing Physician Signature:	**Prescribing Physician Name:**	**Date (DD/MM/YYYY):**

By signing this prescription, I have explained the risks and benefits of the same to my patient and am using my medical judgment to prescribe GLN-APREMILAST. *I have also reviewed and agree to the Physician Consent section on the back of this form I have verbally obtained consent from the patient for the program to contact the patient for the purposes of providing support services.*

Patient signature:	**Patient name:**	**Date (DD/MMM/YYYY):**

By signing above, I wish to participate in the program as described and informed by my treating health care practitioner and I have read and fully understand the Patient Consent terms on the reverse of this form. I consent to the collection, use and disclosure of personal information as described on page 2

PATIENT CONSENT

The Glenmark Canada Patient Support Program (the "Program") is offered by Glenmark Canada ("Glenmark") in order to support eligible patients prescribed Apremilast. The Program is administered by Glenmark and its third-party service provider, SRx Health Solutions ("SRx") and its agents and affiliates (collectively, the "Program Administrator"). This enrolment and consent form outlines how your Personal Information (as defined below) is collected, used and disclosed by the Program. If you have any questions, or if you would like more information about the manner in which the Program treats your Personal Information, or how to access your Personal Information in our records, do not hesitate to contact us using the information provided above.

Why we collect your Personal Information

In order for the Program to offer you the Services (as defined below), the Program will collect, use and disclose personal information such as your name, gender, date of birth, contact information, emergency contact information, medical history (including relevant medical diagnosis, information on current medication, medical allergies, pharmacy information), and insurance/financial information (collectively "Personal Information"). This Personal Information may be collected from you or from your referring physician, pharmacist, insurance company, public payer or any other healthcare professional or payer and you consent to such collection by the Program. The Program will only collect Personal Information required to provide the Services and to comply with our regulatory and legal obligations. The Program, Glenmark and/or the Program Administrator may use your de-identified information (personally identifiable information removed), such as information regarding your health outcome, your demographics and the name and contact information of your healthcare providers such as your treating physician and/or additional Personal Information about yourself in aggregated (combine your information with other information) form in order to research, develop, and improve products and services.

The services provided by the Program may include:

- enrolling you in the Program, including determining your suitability and eligibility for services;
- assisting you in securing coverage for your medication;
- providing pharmacy services; and/or
- providing you with disease state information ("Services").

Access and use of Personal Information

By providing your consent, you understand that the Program may disclose your Personal Information to members of your healthcare team, third parties who assist us in providing Services, and other parties necessary to provide the Services such as your insurance provider. If you provide us with consent, email and text may be used to provide Services. You acknowledge that neither email nor text are secure methods of communication.

The Program does not sell your Personal Information to any third party for any reason. The data contained in your file will only be kept for as long as it is reasonably needed, and it will only be collected, used and/or disclosed as described in this consent form.

You may choose to withdraw your consent at any time by contacting the Program using the information provided above. However, please understand that withdrawing your consent may prevent us from providing you with further Services.

Your information may be stored in secure locations both inside and outside of your province of residence (including in other countries such as the United States), where local laws relating to the protection of personal information may be different. The Program will take reasonable precautions to prevent any loss, misuse, disclosure or modification of Personal Information, as well as any unauthorized access to Personal Information.

Keeping your information accurate

You may update your information by contacting us using the information provided above. Keeping your information up-to-date will assist us in providing you with the Services.

Reporting obligations

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

Changes to the Program

The Program reserves the right to change, modify, or amend the Program (including by changing its Program Administrator). Also, any additional information about privacy policies and practices is available upon request.

PHYSICIAN CONSENT

By signing this form, I acknowledge and agree that: (i) I am the prescribing physician for this patient; (ii) this constitutes an original prescription for GLN-Apremilast; (iii) I authorize the Program to send the prescription to the patient's pharmacy of choice on my behalf; (iv) I have discussed the Program with the patient and have either had the patient sign the consent form, or I have obtained verbal consent from the patient to the Patient Consent; and (v) I consent to being contacted by the Program for the purposes of administering the Program including inquiring about my experience with the Program so that services may be improved. I understand that I may revoke this consent by contacting the Program at the contact information set out above.

GLENMARK APREMALIST PATIENT SUPPORT PROGRAM. Fax Completed Form to 1-833-500-0178