ENROLMENT AND CONSENT FORM

HAEGARDA® C1 Esterase Inhibitor Subcutaneous (Human)

BERINERT® C1 Esterase Inhibitor, Human

HAEGARDA® AND BERINERT® PATIENT SUPPORT PROGRAM

PHONE: **1-888-490-4105** • FAX: **1-888-490-4106** • **BRT-Assistance@innomar-strategies.com**

PLEASE SUBMIT COMPLETED FORM BY FAX

PATIENT INFORMATION

Name _____ Address _____

City _____ Province _____ Postal Code _____

Phone ( ) _____ Alt. Phone ( ) _____

Email _____

Date of Birth _____ **Gender:** ☐ M ☐ F

PRESCRIBING INFORMATION (To be completed by the Physician)

HAEGARDA®: Prophylactic treatment (SC)

Recommended dose: 60 IU/kg (SC), twice weekly (every 3-4 days)

☐ 60 IU/kg

Patient weight _____ KG

Total dose _____ IU

Vial Options:

☐ 2000 IU (4mL)

☐ 3000 IU (6mL)

Other Instructions _____

Has HAEGARDA® been ordered from the Blood Bank? ☐ Yes ☐ No

Berinert®: Acute treatment (IV)

Recommended dose: 20 IU/kg (IV)

☐ 20 IU/kg

Patient weight _____ KG

Total dose _____ IU

Vial Options:

☐ 500 IU (10 mL)

☐ 1500 IU (Reduced Volume, 3 mL)

Other Instructions _____

Has Berinert® been ordered from the Blood Bank? ☐ Yes ☐ No

Blood Bank address _____ Blood Bank contact person _____

X **Sign here** _____ _____

Physician Signature Date (MM/DD/YY)

PATIENT TRAINING (To be completed by the Physician)

Training location: ☐ Patient's home ☐ Outpatient clinic ☐ Other _____

I recommend the training to be done with: ☐ Saline only ☐ HAEGARDA® or Berinert® only ☐ No preference

Training Options: ☐ Full (Training and Ancillaries) ☐ Partial (Ancillary Services)

PHYSICIAN INFORMATION

Physician Name _____ Address _____

City _____ Province _____ Postal Code _____

Specialty _____ Hospital/Clinic Name _____

Office Contact Person _____ Phone ( ) _____ Ext. _____

Fax ( ) _____ Alt. Phone ( ) _____ Email _____

I have read and understand the terms and conditions of this Consent (on the back) and have agreed to enrol in the Program. **By signing below, I hereby knowingly and voluntarily authorize the collection, use, disclosure and/or storage of my Health Information in connection with the Program in the manner described in the Consent.** I consent to the receipt of electronic communications from the Administrator and Program Personnel, for the purposes of determining my eligibility for the Program, conducting Program-related activities and in the delivery of Program services to me. Email communications may be sent to the address I have provided. I understand that I can withdraw my consent at any time.

Printed Name of Patient or Legal Representative _____ Legal Representative Relationship to Patient _____

X **Sign here** _____ _____

Signature of Patient or Legal Representative Date (MM/DD/YY)

ENROLMENT AND CONSENT FORM

CSL Behring has contracted the Administrator to provide the HAEGARDA® and Berinert® Patient Support Program ("Program").
By signing this Consent form ("Consent"), I agree and consent to the following:

- My Health Care Providers (my physician, my nurse and my pharmacy), the Administrator and its employees tasked with administering the HAEGARDA® and Berinert® Patient Support Program ("Program Personnel") may collect, use, disclose amongst each other and store my Health Information for the purposes of monitoring the safety of plasma and blood-derived products in Canada, determining my eligibility for the Program, conducting Program-related activities and delivering Program services to me; and
- Program Personnel may contact me and leave messages for me regarding my Health Information or any other information required for the administration of the Program.

I understand that:

- **HAEGARDA® (C1 Esterase Inhibitor Subcutaneous (Human)) is indicated for routine prevention of hereditary angioedema (HAE) attacks in adolescent and adult patients. Berinert® (C1 Esterase Inhibitor, Human) is indicated for the treatment of acute abdominal, facial, or laryngeal attacks of HAE of moderate to severe intensity in pediatric and adult patients. My Health Care Provider(s) have explained the various treatment options available to me. I have also discussed with my Health Care Providers the purpose(s) for which I have been prescribed HAEGARDA® or Berinert® and any risks and benefits in connection thereto.**
- The Program provides, but is not limited to, reimbursement services, financial assistance, delivery of supplies, compliance and adherence support (collectively, the "Program Services"), and is administered by the Administrator;
  I hereby understand and acknowledge that in order to enrol in the Program and receive Program Services, certain personal and medical information about me ("Personal Information" or "Health Information") will be collected from me and my prescribing physician, pharmacist, nurse, insurer, government agency, employer or other sources (together, the "Parties"), as necessary to ensure the accuracy and completeness of this application and to obtain information required to provide the Program Services. Accordingly, on my behalf, I hereby authorize the Administrator to investigate and determine my insurance benefit potential, and direct third party plans under which I am eligible for benefits to release coverage information to the Administrator related to my policy. I authorize my prescribing physician or other Health Care Providers to disclose to the Administrator such information related to my relevant medical condition as may be required by my insurance provider(s) and/or pharmacy to process my insurance claim(s). I also authorize the Administrator to share such information with my insurance provider(s) and/or pharmacy as is required to process such insurance claim(s) and to assist with prescription services;
- Telephone calls to or from the Administrator in the course of its administration of the Program may be monitored or recorded for control of quality and for training purposes;
- Program Personnel will not (i) collect, use, disclose or store my Health Information for any activity other than the activities outlined above, or (ii) disclose my Health Information to anyone (including CSL Behring and its employees) other than my Health Care Providers, unless the Health Information that identifies me is removed (for example, my name and address);
- I may withdraw my consent at any time by mailing or faxing a signed request to the Administrator at the address or fax number set out below, but if I do so, to the extent that such consent is necessary to provide the services under the Program, the Program will be unable to continue providing me with the Program services.
- Withdrawal of my consent will not be retroactive and non-identifiable information already received may still be used and disclosed even after I withdraw my consent;
- Except where prohibited by law, I may obtain a copy of my Health Information and can correct any errors and/or direct any questions regarding the collection, use, disclosure and storage of my Health Information to the Administrator at the address set out below;
- My Health Information may be collected, used, disclosed and/or stored outside of my province or territory or country, and that the laws of those countries, territories or provinces regarding privacy may be less stringent than the laws of Canada and its provinces;
- CSL Behring may elect to transition the Program to another service provider in which case I consent to allow the Administrator to transfer my personal information to the new service provider for the purposes of administering the Program;
- CSL Behring, or its authorized agent, may access my personal information solely for the purposes of auditing the Administrator to ensure the Program is being administered appropriately;
- **The Administrator will treat my Health Information at all times in accordance with applicable law including the federal Personal Information Protection and Electronic Documents Act and any applicable provincial or national privacy legislation.**
- I am entitled to a copy of this Consent.

Administrator is Innomar Strategies Inc. and its affiliates, located at 3470 Superior Court Oakville, Ontario L6L 0C4.
Health Information includes, without limitation, my personal information (name, address, phone number, date of birth, etc.) and personal health information (medical history, medical condition(s), information relating to my treatment, etc.) as reasonably required to provide the services offered by the Program.
Health Care Providers includes, without limitation, my physician(s), nurse(s), pharmacist(s) and the employees and contractors of the Canadian Blood Services and Héma-Québec.
The Program Staff includes employees and consultants of the Administrator.

PHYSICIAN AUTHORIZATION

IMPORTANT: If unable to obtain written consent from patient, please obtain verbal consent.

☐ **I attest that I have read the above Consent Form to the patient noted on this Enrolment Form, and such patient has provided verbal consent.**

Printed Name of Physician

Date (MM/DD/YY)

X Sign here

Physician Signature

Time

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Biotherapies for Life®

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