ENROLMENT AND CONSENT FORM

FOR QUESTIONS, PLEASE CALL: 1-888-490-4105

Hizentra® Subcutaneous Immunoglobulin (Human), 20%

Send completed form to:
Email: **support@cslplus.ca** Fax: **1-888-490-4106**

CSL | PLUS™ PATIENT SUPPORT PROGRAM

PATIENT INFORMATION

Name _____ Gender: ☐ M ☐ F Address _____

City _____ Province _____ Postal Code _____

Phone ( ) _____ Alt. Phone ( ) _____ Date of Birth _____

Preferred communication method: ☐ Phone ☐ Email _____

CSL PLUS PROGRAM SERVICES

☐ Full (Training and Ancillaries)
☐ Partial (Ancillaries Only)

Training location: ☐ In-Home ☐ In-Clinic ☐ Other: _____
☐ Nurse Training Notes ☐ Adherence/Follow-Up Reports

PRESCRIPTION INFORMATION

☐ Initial Order ☐ Renewal ☐ Dosage Change ☐ Additional Training Required Diagnosis: ☐ PID ☐ SID ☐ CIDP

Patient Weight _____ ☐ lbs ☐ kg Dosage _____ grams/week OR _____ grams/every 2 weeks

Height _____ ☐ in ☐ cm

(Please refer to dosing and calculation instructions on the back page.)

Other Instructions (Optional) _____

Has Hizentra® been ordered from the Blood Bank? ☐ Yes ☐ No Blood Bank Name _____

PHYSICIAN INFORMATION

Physician Name _____ Specialty _____

Hospital _____ Address _____

City _____ Province _____ Postal Code _____ Phone ( ) _____

Clinic Patient Care Coordinator _____ Email _____ Fax ( ) _____

PATIENT CONSENT

I have read or been read and understand the terms and conditions of this Enrolment and Consent Form and agree 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 this Enrolment and Consent Form (consent on reverse side).

X Sign here _____ Date (MM/DD/YY) _____
Signature of Patient or Legal Representative

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

VERBAL CONSENT - IMPORTANT: IF UNABLE TO OBTAIN PATIENT SIGNATURE, PLEASE FILL THIS SECTION OUT.

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

X Sign here _____ Date (MM/DD/YY) _____
Physician Signature

Print Name _____ Title _____

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DOSING INSTRUCTIONS:

OPTION A:
Converting IVIG dose to SCIG
- **PID/SID and CIDP indication**

IVIG dosage (grams) ÷ Previous treatment interval (weeks) = SCIG dose grams/week

OR

OPTION B:
Weight-Based Dosing
- **PID/SID: The recommended dose is 0.1 to 0.2 g/kg/week**

Patient Weight (kg) x Dosage (0.1 to 0.2 g/kg/week) = g/week SCIG (Hizentra®)

- **CIDP: The recommended dose for maintenance therapy is 0.2 to 0.4 g/kg/week**

Patient Weight (kg) x Dosage (0.2 to 0.4 g/kg/week) = g/week SCIG (Hizentra®)

Maintain total weekly dose: The weekly dose can be divided into smaller doses and administered by desired number of times per week. For dosing every 2 weeks, double the weekly Hizentra® dose. Provided the total weekly dose is maintained, patients may choose a dosing interval from daily up to biweekly (every 2 weeks).

The CSL PLUS Patient Support Program ("Program") is sponsored by CSL Behring and managed by Bayshore Specialty Rx, Ltd. ("Program Administrator"). The Program includes services related to CSL Behring products and the medical conditions for which they are indicated.

By consenting to this authorization, I consent to the Program Administrator collecting information from, and sharing information with, my healthcare providers and their staff, blood bank(s), pharmacy providers, insurance company, or other healthcare and service providers (collectively, my "Providers") as necessary to provide me with Services (as listed below) under this Program. The information collected and shared may include Personal Information about me or my minor child, including information related to my or my child's contact information, date of birth, medical condition, treatment, care management, and health insurance coverage and claims, any prescription (including fill/refill information), and any other information disclosed in connection with the Services ("Personal Information"). My Personal Information may be anonymized and aggregated with other patients' information by Program Administrator, and provided to CSL Behring and its service providers to report on, assess, audit, monitor, improve and/or evaluate the Program. It may also be used for research, education, business analytics, market research, forecasting, publication, to identify trends such as product utilization, adherence and outcomes. The Program Administrator may also share my de-identified Personal Information with CSL Behring: (i) when disclosure is needed for CSL PLUS to fulfil its regulatory obligations; and (ii) for CSL Behring to measure program participation and effectiveness. CSL Behring will not use my Personal Information for any other purpose unless required or permitted by law.

The Services may include:

(1) enrolment in available patient services programs offered by CSL Behring;

(2) communication about the Program, including contacting me directly to facilitate access to medication and supplies;

(3) providing product support and adherence services;

(4) evaluating the effectiveness of CSL Behring's support program(s); and

(5) any other related support, education, and assistance services related to my treatment with CSL Behring therapy and/or living with my disease (collectively, the "Services").

I understand that CSL Behring may receive de-identified data from the Administrator for purposes of adverse event reporting and to enable CSL Behring to follow up with my Provider(s). Further, I authorize Program Administrator to contact me by mail, telephone and/or SMS/text message, or email for relevant follow-up to any of the aforementioned Services and for potential participation in marketing research activities. Telephone calls to or from the Administrators in the course of their administration of the Program may be monitored or recorded for control of quality and for training purposes.

The Program Administrator will store my information in a secure and confidential database. Access to the database will be restricted to authorized employees of the Program Administrator. The Program Administrator employs safeguards to protect against unauthorized access, disclosure, use, modification or copying. I have the right to request access to any information that the Program Administrator retains on me, subject to applicable legal restrictions, request how my information has been used, and a listing of organizations that have been provided with my information. This information may be obtained by contacting Program Administrator at 1-888-490-4105, privacyofficer@bayshore.ca or 2101 Hadwen Road, Mississauga, ON, L5K 2L3. I may request access to, or correction of, my or my minor child's Personal Information at any time by contacting the Program Administrator at support@cslplus.ca, or by calling 1-888-490-4105.

I understand the file containing my or my minor child's Personal Information will be maintained at the offices of Bayshore, the Program Administrator. Authorized employees, agents and mandataries of Program Administrator will have access to my Personal Information as necessary to administer the Program. Personal Information collected in connection with the Program, including any adverse event information collected about me or my minor child may be stored or processed outside of Canada, including possible transfers to CSL Behring, where it may be subject to the laws of foreign jurisdictions. For information about Bayshore's privacy policies and practices, I can contact Bayshore at the phone number provided below or access a copy of Bayshore's privacy policy at https://www.bayshore.ca/privacy-policy/.

I understand that I may refuse to sign or consent to this authorization. I understand, however, that if I do not sign or consent to this authorization, I may not be able to receive Services. I understand that my treatment with a CSL Behring therapy, payment for treatment, insurance enrolment, or eligibility for insurance benefits are not conditioned upon my agreement to sign or consent to this authorization. I understand that Services provided by CSL Behring are not insurance and that CSL Behring has the right to rescind, revoke, terminate or amend any service at any time without prior notice.

I understand that I am entitled to a copy of this Authorization and Consent Form.

I understand that 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 and my Service history to a new service provider for the purposes of administering the Program.

I understand that I may cancel this authorization at any time by writing a letter requesting such cancellation to Program Administrator at support@cslplus.ca and that this cancellation will end my participation in the 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. Program Administrator will retain the data no longer than the maximum period allowed by law. This authorization will remain in effect for only as long as is needed to fulfil the purposes for which it was collected and in order to comply with applicable laws.

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