conexus
Patient Support Program™

Patient enrolment form

Updated Version November 4, 2020

Phone: 1-833-CONEXUS (266-3987)
Fax: 1-833-247-9843
Email: inqovi@bayshore.ca
Hours of operation: 8 am to 8 pm EST, Monday through Friday

STEP 1: Complete patient information

First name: _____ **Last name:** _____

Primary language: ❑ English ❑ French

Patient record #: _____

Gender: ❑ Male ❑ Female **Date of birth:** DD / MM / YYYY

Address: _____

City: _____

Province: _____ Postal code: _____

Home phone: _____ **Cell phone:** _____

Preferred phone: ❑ Home ❑ Cell

Best time to contact: ❑ Morning ❑ Afternoon ❑ Evening

Deliver product to: ❑ Patient's home ❑ Other: _____

Email: _____

Alternate authorized contact name: _____

Relation to patient: _____ Contact phone: _____

STEP 2: Complete insurance information

First name: _____ **Last name:** _____

Gender: ❑ Male ❑ Female

Primary insurance: ❑ Public ❑ Private ❑ Patient has no insurance ❑ Unknown ❑ Co-payment assistance may be required

Public coverage application: ❑ Yes ❑ No ❑ N/A

If "Yes": ❑ Approved (attached) ❑ Pending

Private insurance application: ❑ Yes ❑ No

Primary private insurer (if known):

Insurance company name: _____

Subscriber name: _____

Policy/group #: _____

STEP 3: Sign patient authorization: *Please include patient signature to provide services.*

PLEASE READ THE CONSENT AND DISCLOSURE SECTION ON THE REVERSE OF THIS FORM AND SIGN IN THE SPACE BELOW.
I, the undersigned, have read the terms and conditions found on the reverse of this form, understand the services offered by the Program and agree to the collection, use, disclosure and storage of my personal information and personal health information in accordance with those terms and conditions.

❑ Verbal Consent: I, the undersigned, have reviewed the terms and conditions found on the reverse of this form with the patient to be enrolled in the Program and have obtained verbal consent from the patient to the collection, use, disclosure and storage of his/her personal information and personal health information in accordance with those terms and conditions.

Signature of patient or legal representative: _____ Date of signature: DD / MM / YYYY

If representative, please specify relationship to patient (spouse, legal guardian, etc.): _____

STEP 4: Complete physician information

Prescriber name (First, Last): _____

Medical licence #: _____

Facility/practice name: _____

Address: _____ City: _____

Province: _____ Postal code: _____

Office contact: _____

Phone: _____ **Fax:** _____

Contact email: _____

Nurse/Navigator/Pharmacist contact

Name (First, Last): _____

Phone: _____ **Fax:** _____

Contact email: _____

STEP 5: Complete diagnosis & clinical information

Primary diagnosis:

❑ Myelodysplastic syndromes (MDS) ❑ Chronic myelomonocytic leukemia (CMML)

Date of diagnosis of MDS/CMML: _____

Line of therapy: ❑ 1st line ❑ 2nd line ❑ 3rd line

Prior exposure to HMA therapy: ❑ Yes ❑ No

MDS diagnosis: ❑ Primary related ❑ Therapy-related

IPSS score: ❑ INT-1 ❑ INT-2 ❑ High ❑ N/A (CMML)

RBC transfusion dependent: ❑ Yes (average units/month: _____) ❑ No

Platelet transfusion dependent: ❑ Yes ❑ No

ESAS Fatigue Score: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Blast count (<20%): ❑ Yes ❑ No

ECOG performance status: ❑ 0 ❑ 1 ❑ 2

STEP 6: Select nursing services (Must "opt in" if service requested)

❑ **Opt in** *Per discussion with patient, while on therapy, the patient will have access to nursing support from the CONEXUS Patient Support Program™.*

STEP 7: Prescription information

INQOVI Fixed dose tablet (35 mg decitabine + 100 mg cedazuridine)

# of tablets per cycle: _____

Take 1 tablet per day, days 1 through 5, every 28 days

PrINQOVI® (decitabine and cedazuridine) is indicated for treatment of adult patients with myelodysplastic syndromes (MDS) including previously treated and untreated, *de novo* and secondary French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System (IPSS) groups.

STEP 8: Read and sign statement of medical necessity

By signing below, I certify that the above-prescribed therapy is medically necessary, and I hereby acknowledge that I am the patient's attending physician, and confirm that the patient has been prescribed INQOVI (decitabine and cedazuridine) as per the Product Monograph.

I authorize CONEXUS Patient Support Program™ to be my designated agent to forward this prescription by fax or other mode of delivery to a pharmacy within the CONEXUS patient support network. This prescription represents the original prescription drug order.

I authorize Taiho and its agents or contractors to forward a prescription for INQOVI, by fax or other mode of delivery, to a pharmacy within the CONEXUS pharmacy network.

The physician is to comply with his/her provincial specific prescription requirements such as e-prescribing, provincial specific form, fax language, etc.

X _____ Date: DD / MM / YYYY

Prescriber Signature

Consult the Product Monograph at https://health-products.canada.ca/dpd-bdpp/index-eng.jsp for contraindications, warnings, precautions, adverse reactions, interactions, dosing, and conditions of clinical use. The Product Monograph is also available through our medical department. Call us at 1-855-260-2642.

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Patient authorization

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Patient name: (First, MI, Last): _____ **Date:** DD / MM / YYYY

I have been prescribed INQOVI and wish to enrol in the CONEXUS Patient Support Program™ provided by Taiho Pharma Canada, Inc. ("**Taiho Canada**") as described more fully below (the "**Program**"). I understand that participation in the Program is not required to access treatment.

I have read and agree to the following:

The Program may collect, use, disclose and store my personal information (e.g., name, address, telephone number, email address, gender) and health information provided by me or by my healthcare professional(s) (collectively, my "**Information**") for the purpose of: determining my eligibility for, and allowing my participation in, the Program; to communicate with me as needed; and to provide me with the following services:

- Pharmacy services, including the dispensing and delivery of my prescription;
- Assisting with reimbursement navigation and financial assistance; and
- Providing nursing services to assist me in compliance with treatment (collectively, "**Program Services**").

I understand that the Program will be administered by a third-party service provider ("**Program Administrator**"), currently Bayshore Specialty Rx Ltd. I authorize the Program and the Program Administrator to obtain further information from, and to share my Information with, my prescribing physician, pharmacist, nurse, insurer, or employer (collectively, "**Parties**") as required to ensure the accuracy and completeness of this enrolment form, to enrol me in the Program and to provide me with Program Services. I understand that the provision of nursing services by the Program may result in laboratory results, and that these results will be shared with Parties, as needed. Neither the Program nor the Program Administrator is authorized to collect, use or disclose my Information except as necessary to provide me with Program Services or to otherwise comply with legal requirements.

I understand that Taiho Canada and/or the Program Administrator may contact me in connection with administration of the Program and provision of Program Services and I agree to be contacted regarding the Program, my condition and/or my prescription.

I understand that neither the Program nor the Program Administrator will share my Information with Taiho Canada. However, I understand that my Information may be de-identified and shared with Taiho Canada and the Parties or others for use in performing research, education, business analytics or for other commercial purposes, including by combining my Information with other data for such analyses. In such circumstances, my Information will not be shared by the Program, Program Administrator or Taiho Canada in any way that will allow me to be identified.

I understand that the Program Administrator will have access to my Information, and that all of my Information that is collected and recorded in the Program will be treated and maintained by the Program Administrator in compliance with applicable privacy and health privacy legislation. I understand that my Information may be collected, used or disclosed and/or stored outside of my province/territory or country, and that the privacy laws of those jurisdictions may be less stringent than the laws of Canada and/or my home province/territory.

I understand that I can withdraw my consent at any time and, except where prohibited by law, I may obtain a copy of my Information and can correct any errors by contacting the Program at 1-833-CONEXUS (266-3987). I understand that withdrawing my consent will result in the termination of my enrolment in the Program, but such withdrawal will not be retroactive and any activities relating to my Information that has been collected, used, disclosed and/or stored prior to my withdrawal will not be affected.

I understand that any financial assistance provided to me as a result of my enrolment in the Program may be reportable income to public or private payors or government agencies, and understand that I am solely responsible for any such reporting as well as ensuring compliance with accepting such financial assistance.

I confirm that the Information I have provided in this application is complete and accurate. I understand that Taiho Canada reserves the right at any time and without notice to modify the Program or to discontinue the Program and terminate assistance.

Any reference to Taiho Canada in this form includes Taiho Pharma Canada, Inc. and its affiliates and their respective employees, consultants, agents and representatives, including without limitation, third-party service providers (in particular, Bayshore Specialty Rx Ltd, the current Program Administrator). I understand that any rights that I grant to the Program to collect, use and/or disclose my Information, as well as any obligations the Program has to protect the privacy of my Information are also rights and obligations of these identities and other individuals.

INQ-PM-CA-0001E

REVIEWED BY PAAB

Member of: BIOTECanada

INQOVI® (decitabine and cedazuridine) 35mg / 100mg tablets