Print Form

ONESOURCE™ PATIENT SUPPORT

# ENROLMENT FORM

TELEPHONE: 1.888.SOLIRIS FAX: 1-877-301-2596

SOLIRIS® (eculizumab)

## PATIENT INFORMATION

Patient's Name: First Name Last Name  Date of Birth: d d / m m / y y  Gender: M ☐ F ☐

Parent / Guardian Name:  Patient weight: kg

Home Phone:  Leave messages: Y ☐ N ☐  Preferred time to call: AM ☐ PM ☐ Evening ☐

Other Phone:  Leave messages: Y ☐ N ☐  Preferred time to call: AM ☐ PM ☐ Evening ☐

## PHYSICIAN INFORMATION

Physician's Name:  Email:  Postal Code:

Key Contact/Admin:  Telephone:  Fax:

Nurse:  Telephone:  Fax:

## INFUSION

Please choose ONE of the following locations for infusion: ☐ Home ☐ 3rd Party Infusion Clinic ☐ Other _____

## PRESCRIPTION

**SOLIRIS® (eculizumab) DIN: 02322285**
(Refer to monograph for complete prescribing information)

### ➲ Paroxysmal Nocturnal Hemoglobinuria (PNH)

☐ 600 mg every 7 days for the first 4 weeks, followed by 900 mg for the fifth dose 7 days later, then 900 mg every 14 days thereafter for 12 months.

☐ Other _____ for 12 months

### ➲ Atypical Haemolytic Uremic Syndrome (aHUS)

For patients ≥18 years of age

☐ 900 mg weekly for the first 4 weeks, followed by 1200 mg for the fifth dose 1 week later, then 1200 mg every 2 weeks thereafter for 12 months.

For patients <18 years of age
Administer Soliris based upon body weight for 12 months.

☐ **40 kg and over** - 900 mg weekly x 4 doses - 1200 mg at week 5; then 1200 mg every 2 weeks
☐ **30 kg to less than 40 kg** - 600 mg weekly x 2 doses - 900 mg at week 3; then 900 mg every 2 weeks
☐ **20 kg to less than 30 kg** - 600 mg weekly x 2 doses - 600 mg at week 3; then 600 mg every 2 weeks
☐ **10 kg to less than 20 kg** - 600 mg weekly x 1 dose - 300 mg at week 2; then 300 mg every 2 weeks
☐ **5 kg to less than 10 kg** - 300 mg weekly x 1 dose - 300 mg at week 2; then 300 mg every 3 weeks

☐ Other _____ for 12 months

### ➲ Other Condition _____

☐ Dosage _____

### Meningococcal vaccine

**WARNING**
All patients must be vaccinated with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of Soliris, unless the risks of delaying Soliris therapy outweigh the risks of developing a meningococcal infection; revaccinate according to current medical guidelines for vaccine use*

☐ Previously vaccinated  Date: _____

Meningococcal vaccine, one vial as directed:

For patients ≥ 2 yrs of age: ☐ Menveo ☐ Menactra

☐ Other: _____

For patients < 2 yrs of age: ☐ Menveo

☐ Other: _____

Physician Signature: _____

Date: _____ d d / m m / y y

## PATIENT CONSENT ☐ Patient Consented Verbally

I understand that OneSource Canada has been contracted by Alexion Pharma Canada ("Alexion"), for the purpose of assisting Canadian patients with obtaining access to medical treatment under the OneSource Program.

Signature of Patient/Legal Representative:  Date signed: d d / m m / y y

Address:

**SEE FULL PATIENT CONSENT TERMS ON REVERSE-PLEASE ENSURE YOU HAVE FULLY READ AND UNDERSTAND THE PATIENT CONSENT TERMS**



*NACI Recommendation, Circa 2013

## PATIENT CONSENT

### OneSource Canada is the treatment support program for patients. OneSource provides information, education and assistance.

By signing this Authorization and Consent, you agree to permit (1) your physician(s), and other healthcare providers involved in the treatment of your medical condition ("Providers"); (2) the distributor, pharmacy, infusion clinic or home health agency that supplies or dispenses your medical therapy ("Distributor"); and (3) your health insurer, payor, or patient assistance program ("Payor"); to disclose Protected Health Information (PHI) about you to Alexion Pharma Canada including, but not limited to, its employees, affiliates, sub-contractors, agents, and other representatives (together, "Alexion"), for use and disclosure as described below.

The Protected Health Information ("Information") that may be disclosed includes medical reports, orders, prescriptions, records, histories, findings, prognoses, plans of care and discharge summaries, billing information, insurance claims, and utilization review reports. The Information covered by this Authorization and Consent includes Information provided to Alexion by you, Providers, Distributors and Payors. By signing this Authorization and Consent, you agree to permit Alexion to use and disclose the Information as described below:

**Coordination of Care:** Between you, the Provider, Distributor, or Payor for the coordination of your medical care.

**Disease Management/Patient Education:** To provide information, training, and case management services to you or your representative, or any Provider, Distributor, or Payor.

**Clinical Research/Treatment Protocols:** To inform you or your representative of clinical research studies, treatment protocols, or disease-related surveys.

**Reviewing your Insurance Coverage:** To review, verify, and assist you in understanding the services your Payor covers.

**Billing and Payment:** To coordinate the preparation, filing, and processing of health insurance claims, the evaluation of coding (billing) issues, and the resolution or collection of any payment due to Provider, Distributor, Payor or Alexion for your medical care.

**Distribution of hematologic therapy:** To coordinate the distribution of the medical product to you.

**Product Orders:** To fulfill product orders and answer questions that you may provide to the Alexion call center, and otherwise to inform you about other services that may be of interest.

**Government Agencies:** To provide information as required or requested by representatives of government agencies.

**Other Use of Information:** To de-identify the information about you and to use this de-identified information in performing clinical research, patient and community education, clinical protocol development, marketing studies, or for other commercial purposes as determined by Alexion.

**Transfer of Personal Information:** To transfer the Information between provinces of Canada, and to transfer the Information outside of Canada. In addition, consent and authorization is granted to store the Information on Alexion's behalf outside of Canada.

This Consent and Authorization may be revoked by me at any time by sending a written notice to Alexion.

### SOLIRIS® (eculizumab) indication:

SOLIRIS® (eculizumab), indicated for atypical Hemolytic Uremic Syndrome (atypical HUS) in children less than 13 years of age and/or weighing less than 40 kg, has been issued marketing authorization with conditions, pending the results of studies to verify its clinical benefit. Patients should be advised of the nature of the authorization. For further information for SOLIRIS please refer to Health Canada's Notice of Compliance with conditions – drug products website: **http://www.hc-sc.gc.ca/dhp-mps/prodpharma/notices-avis/conditions/index-eng.php**.

SOLIRIS® (eculizumab), has been issued marketing authorization without conditions for adults and adolescents aged 13-17 weighing more than 40 kg with atypical Hemolytic Uremic Syndrome (atypical HUS) and for Paroxysmal Nocturnal Hemoglobinuria (PNH).