# ENROLMENT FORM

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EMAIL: MAPinfo@innomar-strategies.com

## PATIENT INFORMATION

Patient's name: First name Last name  Date of birth: dd/mm/yy  Gender: F ❑ M ❑

Parent/guardian name:

Address:

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: | Specialty: | License number: |
| Email: | Address: | Postal Code: |
| Key contact/admin: | Telephone: | Fax: |
| Nurse: | Telephone: | Fax: |

## PRESCRIPTION

**STRENSIQ® (asfotase alfa)** (Refer to monograph for complete prescribing information)

Patient's body weight: _____kg  Patient's height: _____cm

Dosage:

❑ 2 mg/kg of body weight administer _____mg subcutaneously 3 times per week for 4 weeks

❑ 1 mg/kg of body weight administer _____mg subcutaneously 6 times per week for 4 weeks

Repeats: _____

Directions/special instructions: _____

**Physician signature:** _____

**Date:** _____ dd/mm/yy

## PATIENT AUTHORIZATION AND CONSENT

❑ Patient consented verbally

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

**Signature of patient/legal representative:** _____

**Date signed:** _____ dd/mm/yy

**SEE FULL PATIENT CONSENT TERMS BELOW—PLEASE ENSURE YOU HAVE FULLY READ AND UNDERSTAND THE PATIENT CONSENT TERMS**

### The Metabolic Assistance Program is the support program that provides information, education and assistance to patients.

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, 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 the uses and purposes described below.

PHI that may be disclosed includes diagnoses, medical reports, orders, prescriptions, records, medical histories, findings, prognoses, plans of care and discharge summaries, billing information, insurance claims, and utilization review reports. The PHI and other information covered by this Authorization and Consent includes PHI and other information provided to Alexion by you, Providers, Distributors and Payors. The uses and purposes to which your PHI and other information may be put are:

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. This may include review of your personal financial information to determine if you qualify for financial assistance which may be available under the Metabolic Assistance Program. If you do not qualify for insurance or other coverage to pay for your treatment, your PHI and other information may be used to determine if you might qualify in future for such coverage.

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 treatment.

Product Orders: To fulfill medical product orders, answer any questions that you may have and to inform you about other services that may be of interest to you.

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

Other Use of Information: To de-identify the PHI about you and to use this de-identified PHI 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 PHI and other information between provinces of Canada, and to transfer the PHI and other information outside of Canada. In addition, consent and authorization is granted to store the PHI and other information on Alexion's behalf outside of Canada.

This Consent and Authorization may be revoked by you at any time by sending a written notice to Alexion at 3100 Rutherford Road, Suite 300, Vaughan, Ontario L4K 0G6.

### STRENSIQ (asfotase alfa) indication

STRENSIQ (asfotase alfa), indicated as enzyme replacement therapy for patients with confirmed diagnosis of paediatric-onset hypophosphatasia, has been issued marketing authorization with conditions, pending the results of trials to verify its clinical benefit. Patients should be advised of the nature of the authorization. For further information for STRENSIQ please refer to Health Canada's Notice of Compliance with conditions – drug products web site: **http://www.hc-sc.gc.ca/dhp-mps/prodpharma/notices-avis/conditions/index-eng.php**