Patient Assistance Program Enrollment and Consent Form

Form cannot be processed without physician's signature for initial request and patient's / legal representative's signed consent.
Fax this completed form to **1-800-268-0774** or email to customer.relations1@astrazeneca.com.
Please complete ***all fields*** to minimize delays. For immediate inquiries, please call 1-800-668-6000.

Inclusion Criteria: (must fulfill all criteria)

- Patient must be a Canadian Citizen or Canadian Resident.
- No generic alternative is listed on the provincial formulary.
- Patient cannot afford this drug and has no other source of provincial funding coverage and/or patient cannot afford the deductible, if province offers coverage.
- Patient does not have any coverage with their private drug plan.
- Patient does not meet provincial listing criteria and/or Non-Insured Health Benefits (NIHB) listing criteria.

SECTION 1: PATIENT INFORMATION

Patient First Name:	Patient Last Name:
Date of Birth (DD/MM/YYYY):	Gender: M☐ F☐ Language: Eng☐ Fre☐
Legal Representative Name (if applicable):	
Patient Home Province:	
Email Address:	
Best time to be reached: ☐ Morning ☐ Afternoon ☐ Evening	
Home Phone:	Alternative Phone:
May we leave a voicemail or message with someone who answers? Yes☐ No☐	
Is this the first enrollment? Yes☐ No☐	

SECTION 2: PATIENT CONSENT– see full patient consent and privacy information section on next page. Please ensure you have read and fully understand this information.

My signature below confirms that I have read and understand the Patient Consent and Privacy Information section and agree to the collection, use and disclosure of my Personal and Financial Information in accordance with those terms. I understand that if I am approved to receive Product, the maximum term for receiving such Product is 1 year, unless I receive further approval after the 1 year.

Patient or Legal Representative Signature:

Date (DD/MM/YYYY):

If verbal consent received (Not applicable in Alberta and New Brunswick): The Patient or Legal Representative has read the Patient Consent and Privacy Information section and provided his/her verbal consent to the collection, use and disclosure of his/her Personal and Financial Information in accordance with those terms.

Name of person who collected the patient's or legal representative's verbal consent:

Date on which verbal consent provided (DD/MM/YYYY):

SECTION 3: PRESCRIBING PHYSICIAN INFORMATION

First Name:	Last Name:	
Clinic Name and Address:		
Administrator/Office Contact Name:		
City:	Province:	Postal Code:
Office Contact Email Address:		
Office Phone:	Office Fax:	

SECTION 4: PRODUCT INFORMATION

Drug Name, Strength & Dosage (e.g. 5 mg OD):

Does the patient meet ALL of AstraZeneca's inclusion eligibility criteria listed above? Yes☐ / No☐

If approved, a 3-month supply will be initially shipped to the physician's office. A verbal or written request is required for each subsequent 3-month resupply.

A new form must be filled out after 1 year OR if drug/dose has changed.

SECTION 5: PRESCRIBING PHYSICIAN AUTHORIZATION

I certify that I am the patient's prescribing physician and confirm that the patient has been prescribed the Product as per the Canadian Product Monograph based on my independent medical judgment and the patient's informed consent.

I state that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient has no prescription insurance coverage for the prescribed medication, and the patient has insufficient financial resources to pay for the prescribed therapy.

The Products received from AstraZeneca Canada Inc. will be used by the above-indicated patient only.

AstraZeneca reserves the right to request and to collect Personal and Financial Information to confirm that the patient meets the above criteria for new and repeat requests. In that event, patient will need to provide the requested information and consent in writing to AstraZeneca gathering and maintaining that information for the purpose of this assessment.

Physician Signature: (Stamps or proxy signatures will not be accepted)

Date (DD/MM/YYYY):

Confidentiality Notice: This message is private and may contain confidential, proprietary and legally privileged information. If you have received this message in error, please notify us and remove it from your system and note that you must not copy, distribute or take any action in reliance on it. Any unauthorized use or disclosure of the contents of this message is not permitted and may be unlawful.
Information from your request will be documented within our AstraZeneca database. AstraZeneca Canada is committed to protect and control the collection, use and disclosure of personal information of individuals that interact with us in accordance with applicable Canadian privacy laws. For further information regarding our Privacy Policy, please refer to our website at www.astrazeneca.ca. The AstraZeneca logo is a trade-mark of the AstraZeneca group of companies

The Program is sponsored by AstraZeneca Canada Inc. (**"AstraZeneca"**) and is administered by NavieGo Programs. (**"Program Administrator"**), an independent third party. AstraZeneca may change the Program Administrator at its sole discretion without notice.

You understand that the Program is intended to assist patients by investigating their reimbursement options for their treatment and providing financial support if applicable. It is not intended to provide medical advice or medical diagnoses. You should always seek the advice of your physician if you have any health concerns. You have discussed the benefits and risks of the Product with your physician and have decided to start treatment. You understand that (i) it is your right to refuse to sign this consent form, (ii) if you do not give such consent, you will not be provided with access to the Program, (iii) if access to the product or generic is available to you outside of this Program, you will no longer receive support from our Program, and iv) enrollment in the Program does not guarantee approval.

You understand that the information contained and the requested documentation for this application is complete and accurate. You confirm you have insufficient financial resources to pay for the prescribed therapy. You acknowledge that the Products received from AstraZeneca Canada Inc. are strictly for personal use, and that coverage is at the discretion of AstraZeneca's Patient Assistance Program. AstraZeneca reserves the right at any time, without notice, to modify the Program or to discontinue the Program and terminate assistance.

By signing this form, you agree to enroll in the Program and authorize your information, including contact information and information about your finances, insurance, prescriptions, medical condition, and other health information ("**Personal Information**") to be collected, used and disclosed as described below. In addition, you consent to the Program Administrator contacting you to provide the Program services. Such authorization and consent being your "**Personal Information Consent**".

Personal Information: Collection, Use and Disclosure

To participate in the Program, you are required upon request to provide your Personal Information (e.g. proof of Canadian Citizenship/Resident or eligibility in province) and Financial Information (e.g. copy of last year's Canadian income tax return, 2 current paystubs, or income statements from jobs last year) to the Program Administrator and you authorize the Program Administrator to contact your insurer, and your healthcare providers for additional information.

Your Personal Information will be collected, and may be used and disclosed by the Program Administrator for audit and quality assurance purposes including:

- public and private insurers for the purpose of investigating drug reimbursement options; and
- healthcare provider(s), who may share your Personal Information with your insurers for the purpose of investigating drug reimbursement options

Your Personal Information collected as part of the Program will be protected by reasonable physical administrative and technical safeguards to protect it against loss, theft and unauthorized consultation, communication, copying, use or alteration.

Your Personal Information may be de-identified and used for various purposes, including to help AstraZeneca assess and improve patient assistance programs and how it provides products and services to patients and healthcare professionals.

I understand the file containing my information will be maintained at the offices of the Program Administrator. Authorized employees, agents and mandataries of the Program Administrator may have access to my information where necessary for purposes described in this form.

I may request access to, or correction of, my Personal Information at any time by contacting the Program Administrator at NavieGo Patient Programs Ltd & Affiliates at 1234 Main St., Suite 400 Moncton, NB, Canada E1C 1H7.

If AstraZeneca appoints a new program administrator to replace the Program Administrator, I agree my Personal Information may be transferred to the new service provider.

Drug Safety

AstraZeneca is legally required to report adverse drug events to Health Canada and to monitor Product complaints. As such, AstraZeneca, its representatives and the Program Administrator may use and report your personal information to regulators for drug safety and quality purposes. You or your physician may be contacted for additional information to fulfill these obligations.

Consents can be Withdrawn

You may withdraw your Personal Information Consent and/or any reimbursement information consent at any time by sending a letter to NavieGo Patient Programs Ltd & Affiliates at 1234 Main St., Suite 400 Moncton, NB, Canada E1C 1H7. You understand that withdrawal of your Personal Information Consent will end further uses and disclosures of the Personal Information and will end your enrollment in the Program. You understand that withdrawal of any reimbursement information consents will not impact further uses and disclosures of the Personal Information and will not end your enrollment in the Program. Any withdrawal of consent will not be retroactive and any activities relating to your Personal Information prior to your withdrawal will not be affected. You may ask any questions about privacy and compliance to the Program Administrator's Privacy Officer by email (gmaher@bioscript.ca) or telephone (403-471-4779; toll free: 1-888-734-3814).

For information on the Product, please consult the patient healthcare provider(s), who may share your Personal Information with your insurers for the purpose of investigating drug reimbursement options.