FERRING
PHARMACEUTICALS

Ferring Patient Assistance Program Form

Ferring Inc. developed the Patient Assistance Program for Canadian patients requiring financial support. The program is available to all eligible Canadians who qualify.

To determine if you qualify, you and your doctor must first complete and submit the application form below. It is important to fill out all the requested information to avoid delays in processing your application. We have included a checklist at the bottom of this page to guide you through each step.

In order to be eligible, one must meet all of the following requirements:

- Have a maximum yearly gross household income as listed in table hereunder:

Number of People in Your Household	Maximum Yearly Gross Household Income[1]
1	**$24,600**
2	**$30,625**
3	**$37,650**
4	**$45,712**
5 or more	**$51,846**

- Not have private insurance for the product being requested.

The submission of a complete application form does not guarantee enrollment in the Patient Assistance Program. You will receive confirmation of the status of your request by mail or email (approved/declined) once your application has been processed. Please allow 21 business days for processing. Please use the checklist below to make sure your application is complete.

APPLICATION CHECKLIST

DOCTOR

- ☐ Complete all fields in Section 1 & 2.
- ☐ Sign and date the application form (No stamps, only original signatures accepted).

PATIENT

- ☐ Fill out your personal information in Section 3.
- ☐ Fill out your financial information in Section 4.
- ☐ Read and sign the consent in Section 5 and have each applicable household member read and sign the consent in Section 6.
- ☐ Attach a copy of the initial Notice of Assessment received from Revenue Canada for the most recent year for all adults in household.

When the form is complete (both checklists above), send us your form by mail, fax or email.
REMEMBER: incomplete or incorrect information may cause processing delays. Therefore, please ensure that all required information is provided, that it is accurate and that all signatures are included.

Mail: FERRING Patient Assistance Program
200 Yorkland Blvd
Suite 500
Toronto, ON M2J 5C1
Attn: Patient Assistance Program Coordinator
Fax: (416) 642-1656
Email: pap@ferring.com

[1]Based on Statistics Canada; Low income cut-offs (before tax, population 500,000 and over) 2015
http://www12.statcan.gc.ca/census-recensement/2016/ref/dict/tab/t4_4-eng.cfm

FERRING PHARMACEUTICALS

SECTIONS 1-2 TO BE COMPLETED BY PHYSICIAN
(Please print clearly)

SECTION 1 PATIENT INFORMATION

_____ _____ _____
First Name **Last Name** **Date of Birth (DD/MM/YYYY)**

TREATMENT DETAILS

Has FERRING Patient Assistance Program been requested previously for this patient? Yes ☐ No ☐

Product Name: _____ **Strength:** _____

Daily Dosage: _____ **# Of Treatment Days:** _____

SECTION 2 PHYSICIAN INFORMATION & CONSENT

_____ _____
First Name **Last Name**

_____
Address

_____ _____ _____
City **Province** **Postal Code**

_____ _____ _____
Telephone **Fax** **Licence Number**

PHYSICIAN CONSENT

By signing this document, I consent to the collection, use and disclosure of my personal information by Ferring employees for accounting, eligibility and processing purposes and any other use, retention and disclosure required in connection with the Patient Assistance Program, including retention of such information for as long the relevant patient is participating in such program and for a reasonable period thereafter. I consent to the release of my information to a third party for the purpose of verification of such information. For more information on privacy, please consult www.Ferring.ca.

I understand that the requested Patient Assistance Program is being made possible by Ferring Inc. The drug provided will only be used according to labeling approved by Health Canada (e.g. approved indication, dose, contraindications, dosing regimen).

I understand Ferring Inc. reserves the right to determine quantity of product supplied and may terminate this program at any time at its sole discretion. The maximum number of months of treatment provided is 3 or 1 infertility cycle. Should treatment be requested beyond this period, a new request must be submitted referencing the original request and will be subject to independent evaluation.

I understand that any product provided by Ferring under this program will be dispensed only to the patient identified on this form and free of charge. Any product that is received but not administered to the patient identified on this application is to be returned to Ferring Inc. Health Care Professionals are responsible, at the minimum, to report serious adverse events to Ferring Inc. Medical Information and Pharmacovigilance Department at 1-866-384-1314 or Health Canada at 1-866-234-2345 or online at www.healthcanada.gc.ca/medeffect

Physician's Signature _____ **Date** _____
(Original signature – No stamps)

SECTIONS 3-6 TO BE COMPLETED BY PATIENT OR PARENT/LEGAL GUARDIAN
(Please print clearly)

SECTION 3 PATIENT PERSONAL INFORMATION

_____ _____
First Name **Last Name**

☐ **FEMALE** ☐ **MALE** _____
Gender **Date of Birth (DD/MM/YYYY)**

_____
Address

_____ _____ _____
City **Province** **Postal Code**

_____ _____
Telephone **Email**

_____ _____
Contact Name if other than patient **Relationship to Patient**

SECTION 4 PATIENT OR PARENT/LEGAL GUARDIAN INFORMATION

Do you have private insurance for the product requested? Yes ☐ No ☐

Number of people in your household: adults= _____ children= _____

Yearly gross household income (before taxes): $_____

You must provide proof of the total yearly gross household income to submit an application for this program. Please provide a copy of the initial Notice of Assessment received from Revenue Canada for the most recent year for EACH adult in your household.

SECTION 5 PATIENT CONSENT

By signing this document, I consent to the collection, use and disclosure of my, and my minor childrens', personal and/or medical information by Ferring Inc. for accounting, eligibility and processing purposes and any other use, retention and disclosure required in connection with the Patient Assistance Program, including retention of such information as long as I/my child is participating in such program and for a reasonable time thereafter. I consent to the release of my and my minor childrens', personal and/or medical information to a third party including, without limitation, credit reporting agencies for the purpose of verification of such information.
I understand Ferring Inc. reserves the right to determine quantity of product supplied and may terminate this program at any time at its sole discretion.

Patient First Name and Last Name (Print) _____

Signature of patient or applicant if other than patient _____Date: _____

SECTION 6

HOUSEHOLD CONSENT

Each person providing a Notice of Assessment to determine eligibility of the applicant must provide consent.
By signing this document, you consent to the collection, use and disclosure of your information by Ferring Inc. for accounting, eligibility and processing purposes and any other use, retention and disclosure required in connection with the Patient Assistance Program, including retention of such information as long as the applicant is participating in such program and for a reasonable time thereafter. You also consent to the release of your personal information to a third party including, without limitation, credit reporting agencies for the purpose of verification of such information.

Name (First and Last): _____
Please Print

Signature: _____ Date: _____

Name (First and Last): _____
Please Print

Signature: _____ Date: _____

Name (First and Last): _____
Please Print

Signature: _____ Date: _____