FERRING
PHARMACEUTICALS

Ferring Infertility Oncology Patient Assistance Program Form

Ferring Inc. developed the Infertility Oncology Patient Assistance Program for Canadian patients requiring financial support due to a diagnosis of Cancer.

To 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.

The submission of a complete application form does not guarantee enrollment in the Infertility Oncology Patient Assistance Program. Please allow 48 hours for review and notification of approval or denial and confirmation of products being supplied with quantity. Notification will be sent by email or mail. Product will be shipped to the doctor's office to arrive within 5 business days. 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 and 4.
- ☐ Read and sign the consent in Section 5.

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

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 Infertility Oncology Patient Assistance Program been requested previously for this patient?

Yes ☐ No ☐

Diagnosis: _____

Referring Oncologist name: _____

Product Name: _____ Strength: _____

Daily Dosage: _____ Number of days: _____

Product Name: _____ Strength: _____

Daily Dosage: _____ Number of days: _____

SECTION 2 PHYSICIAN INFORMATION & CONSENT

_____ _____

First Name **Last Name**

_____

Email address

_____

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 Infertility Oncology 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 Infertility Oncology Patient Assistance Program is being made possible by Ferring Inc. The drug provided will only be used according to labeling approved by Ferring and/or Health Canada (e.g. approved indication, dose, contraindications, dosing regimen). Confirmation of the patient's cancer diagnosis will be retained on file and will be disclosed to Ferring Inc., if required, as it pertains to providing the drug product under this program.

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 treatment provided is for 1 infertility cycle.

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. The product is being provided to the requesting patient based on a diagnosis of cancer. Patients seeking assistance without a cancer diagnosis are not eligible for this program. 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 3-4 TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN (Please print clearly)

SECTION 3 PATIENT PERSONAL INFORMATION

_____ _____

First Name **Last Name**

_____

Email address

_____

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 CONSENT

By signing this document, I consent to the collection, use and disclosure of my 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 Infertility Oncology Patient Assistance Program, including retention of such information as long as I am participating in such program and for a reasonable time thereafter. I consent to the release of my personal and/or medical information to such third parties as may be required to implement the program. 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: _____

Name of applicant/legal guardian if other than patient _____