FIRMAGON®+ PATIENT SUPPORT PROGRAM ENROLLMENT FORM

This enrollment form serves as your prescription for Firmagon® (degarelix). When filled out and signed, send this form to Firmagon®+ Patient Support Program administered by NavieGo Patient Assistance Program via Fax: **1-866-963-6488.**

For more information or any questions call the Program at 1-866-287-6488 or email info@firmagonplus.ca.

PRESCRIPTION for FIRMAGON®

Directions: 240 mg subcutaneous induction, then 80 mg subcutaneous maintenance monthly.

Months on Treatment (#) ☐

Initial dose administered on: ☐ (do not dispense induction dose)
yyyy/mm/dd

Dispense Monthly

No further refills ☐

Special Instructions:

☐ I verified that the patient named below meets the following criteria for prescribing.

Firmagon® (degarelix) is a gonadotropin-releasing hormone (GnRH) receptor antagonist (blocker) indicated for testosterone suppression in patients with advanced hormone-dependent prostate cancer in whom androgen deprivation is warranted.

PATIENT INFORMATION

First Name | Last Name

DOB (yyyy/mm/dd) | Language Preference ☐ English ☐ French

Address

City | Province | Postal Code

Home Phone | Cell Phone | Email

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Email

Voicemail Allowed? ☐ Y ☐ N

Emergency Contact Name | Emergency Contact Number

PHYSICIAN INFORMATION (to be completed by the physician)

First Name | Last Name

License | Language Preference English French

Address

City | Province | Postal Code

Phone | Fax | Email

Preferred method of contact: ☐ Email ☐ Fax ☐ Phone

PLEASE SELECT OPTIONS BELOW: (as required)

Reimbursement Services Required: ☐

Injection Services Only: ☐

PATIENT AUTHORIZATION

Patient or Legally Authorized Representative:

Signature (Required) | Name of Legal Representative

Date (yyyy/mm/dd) | Relationship to Patient

PHYSICIAN AUTHORIZATION

Physician signature (Required) | Date (yyyy/mm/dd)

I certify that this prescription is an original and the pharmacy chosen by the patient is the only recipient. The original prescription will be invalidated by marking it in such a way that it cannot be reissued.

By signing this form, I agree to have read, understood and accepted the Terms and Conditions on the reverse side.

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PHYSICIAN TERMS AND CONDITIONS

I, the prescribing physician for the patient identified on this form, understand the services offered by the Firmagon® + Patient Support Program herein referred to as "the Program".

I confirm that: (i) I have met with the patient and discussed the Program with him; (ii) the patient understands the Program; (iii) the patient is interested in enrolling in the Program; (iv) the patient has consented to me filling out the form which includes adding personal information of the patient, and communicating it to the NavieGo Patient Support Program Administrator and its affiliates herein referred to as "NavieGo" for purposes of enrollment in the Program; and (v) the patient agrees to be contacted by NavieGo to initiate his enrollment in the Program. I certify that my patient's condition is within the indications listed in the current Firmagon® (degarelix) Product Monograph and that the dosage is appropriate based on my clinical judgement. I understand that I may be contacted by NavieGo, as set forth in the "Physician Information" provided above, for the purpose of receiving relevant information related to services provided to the patient.

I also consent to be contacted by NavieGo, as set forth in the "Physician Information" provided above, for the purpose of inquiring about my experience with the Program so that services may be improved. I understand that I may revoke this consent at any time by sending a signed request to NavieGo at 1-1393 North Service Rd. East, Oakville,Ontario, L6H 1A7, fax 1-866-963-6488, or email info@firmagonplus.ca. I consent to the use and transfer of my name, licence number, and coordinates to the appropriate public payers to assist with the transfer of my patient into the public program, where applicable. I also agree to the disclosure of appropriate clinical documentation to controllers and auditors contracted by Ferring (the manufacturer of Firmagon®) for audit purposes, to the extent that such disclosure is in accordance with the Terms and Conditions. I agree to the disclosure of my licence number and coordinates to Ferring for reporting purposes including, but not limited to, research, development, and sales data. I understand that should my patient meet the criteria to continue in the Program, a new prescription will be required. I understand that should my patient continue in the Program, this consent extends to the duration of my patient's involvement in the Program. I understand that Ferring reserves the right to terminate, modify, and/or transfer the Program to another third party at any time for any reason.

PATIENT TERMS AND CONDITIONS

I understand that the objectives and purposes of the Firmagon® + Patient Support Program, herein referred to as "the Program," consist of offering confidential patient-support services, free of charge, designed for patients who have been prescribed Firmagon® (degarelix). I will be offered, depending on my eligibility or need: reimbursement assistance, pharmacy, and clinic delivery services. I understand that this consent includes all the terms and conditions listed with respect to the initial treatment I will be receiving and should my physician recommend further treatment, my consent extends to my continued participation in the Program.

I have been given the opportunity to discuss the Program with my healthcare provider (i.e. doctor or nurse) and I understand that participation in the Program is voluntary. I agree and give my consent, to my healthcare provider and my health insurer to provide details of my personal information (which may include my name, address, email address and phone number, financial information as well as sensitive personal health information including my medical history, my medical condition and other health information, health insurance information as well as all information included on this form) to the NavieGo Patient Support Program Administrator and its affiliates herein referred to as "NavieGo"; by any means of communication whatsoever (including email, fax or verbally by phone), as may be required for the purpose of determining my eligibility for participation in the services offered by the Program or for purposes of administering the Program. I also authorize my healthcare provider to provide NavieGo with this completed form.

I understand and agree that, when communicating with me or performing the services, as the case may be, NavieGo will ask me to identify myself by asking me questions for purposes of authentication. I understand that NavieGo may, for such purpose, ask for my full name, date of birth, email address, full address (including my postal code) as well as my phone number. I understand that in carrying out these activities and as required for the management of my file in the Program, my personal information may also be exchanged among my healthcare provider, my health insurer, nurses, physicians and pharmacists.

I understand NavieGo is responsible for the collection, use and disclosure of my personal information collected for the purposes of the Program, as described in this form. I understand that Ferring may receive aggregate and/or anonymized data in respect to the Program, but will not receive my personal information, except, if required, in the following special circumstances: (i) if a complaint form is filled out by a patient or a physician; (ii) if a healthcare provider has a special request that would require pre-authorization from Ferring; (iii) if a healthcare provider receives special instructions on an enrolment form that would require Ferring's involvement in coordinating the request; or (iv) in the case of an adverse event, as required by law, to enable Ferring to follow up with my healthcare provider.

I understand that the file(s) containing my personal information will be maintained at the office of NavieGo located at 1-1393 North Service Rd. East, Oakville, Ontario, L6H 1A7. I understand that NavieGo will collect, use, disclose and protect my personal information, as described in this form, and in accordance with its privacy policy, available at http://www.bioscript.ca/privacy-policy. I further understand that authorized employees, agents and representatives of NavieGo will have access to my personal information to the extent necessary to administer the Program. I understand that my personal information will not be used by NavieGo for any purpose other than the administration of the Program.

I may request access to, or correction of, my personal information, as well as any other information or support in relation to the Program by contacting NavieGo in writing at the following address: 1-1393 North Service Rd. East, Oakville, Ontario, L6H 1A7, fax 1-866-963-6488, or email info@firmagonplus.ca.

I may revoke my consent to participate in the Program at any time by sending a signed request to my healthcare provider, health insurer(s) or to NavieGo at 1-1393 NorthService Rd. East, Oakville, Ontario, L6H 1A7, fax 1-866-963-6488, or email info@firmagonplus.ca. However, I understand that if I withdraw my consent, such withdrawal will have no retroactive effect (it will be effective as of the date of receipt of my withdrawal notice). I also understand that if I withdraw my consent I will not be able to receive services from NavieGo, including but not limited to, financial assistance and reimbursement. Any personal information already provided will be retained by NavieGo for purposes of documenting the management of services provided to that point until such information is no longer required for such purposes. Withdrawing my consent will result in the termination of my enrollment in the Program.

I understand that Ferring reserves the right to terminate, modify and/or transfer the Program at any time for any reason. I have read the above Program terms and conditions herein referred to as "Terms and Conditions", and I agree to the collection, use and disclosure of my personal information, including my sensitive personal health information, in accordance with the Terms and Conditions. I understand the services offered by the Program as well as my rights set forth in the Terms and Conditions and I am aware that I am entitled to a copy of this document.