FIRMAGON®+ PATIENT SUPPORT PROGRAM
ENROLMENT FORM

Send this completed form to the Firmagon®+ Patient Support Program via fax: **1-866-963-6488**
For more information or questions, contact the Program at 1-866-287-6488 or email firmagonplus@bayshore.ca, Monday to Friday 8:00am to 8:00pm EST.

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB (DD/MMM/YYYY): _____ Gender: ☐ Male

Health Card #: _____ Language Preference: ☐ English ☐ French ☐ Other: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Best Time to Call: ☐ AM ☐ PM Voicemail Allowed? ☐ Yes ☐ No

*Email: _____ Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

Alternative Contact: _____ Relationship: _____ Phone Number: _____

*I agree to receive electronic communications from the Program Administrator, Bayshore Specialty Rx Ltd. ("Bayshore") acting on behalf of Ferring Inc. containing information and updates relating to my enrolment in the Firmagon® + Patient Support Program. I understand that I may withdraw my consent to such communications at any time by providing notice to the Program Administrator at 2101 Hadwen Rd., Mississauga, Ontario L5K 2L3 or firmagonplus@bayshore.ca.

MEDICAL CRITERIA & DIAGNOSIS

☐ Advanced hormone-dependent prostate cancer

Known Allergies: ☐ No ☐ Yes, please specify: _____

Special Instructions: _____

PHYSICIAN INFORMATION

First Name: _____ Last Name: _____ License Number: _____

Clinic Name: _____ Address: _____ City: _____

Province: _____ Postal Code: _____ Phone Number: _____ Fax Number: _____

Email: _____ Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Email

Primary Contact: _____ Phone Number: _____ Fax: _____ Email: _____

PRESCRIPTION INFORMATION (to be completed by the physician)

☐ Starting dose: 240 mg given as two subcutaneous injections of 120mg.
Starting dose was administered on (DD/MMM/YYYY): _____. Do not dispense starting dose if already administered.

☐ Maintenance dose: 80 mg given as one subcutaneous injection. The first maintenance dose should be given one month after the starting dose.
Duration: _____ months.

☐ I verify that the above-named patient meets the indication and clinical use as described in the Health Canada approved Product Monograph for Firmagon®. I hereby certify that this is an original prescription. I hereby authorize the Firmagon®+ Patient Support Program to be my designated agent to forward this prescription by fax, or other mode of delivery, to a pharmacy chosen by the above-named patient. This prescription ensures that the patient obtains access to the therapy I have prescribed for advanced hormone-dependent prostate cancer in whom androgen deprivation is warranted. This prescription shall not be reused. This prescription expires one (1) year from the date of signature below.

Physician Signature: _____ Date (DD/MMM/YYYY): _____

PHYSICIAN AUTHORIZATION

I acknowledge that I have read and understood the Firmagon®+ Patient Support Program Terms & Conditions and Physician Disclosure and Consent described in this form (collectively, the "**Physician Terms**"). I consent to the collection, use, access and disclosure of my Prescriber Information by the Program Administrator, Ferring and Ferring's agents, in accordance with the Physician Terms. I further consent to being contacted from time to time by the Program Administrator, Ferring and Ferring's agents in accordance with the Physician Terms.

Signature: _____ Name (please print): _____ Date (DD/MMM/YYYY): _____

PATIENT/LEGAL REPRESENTATIVE AUTHORIZATION

I acknowledge that I have read and understood the Firmagon®+ Patient Support Program Terms & Conditions and Patient Disclosure and Consent described in this form (collectively, the "**Patient Terms**") and provide consent to my physician to enrol me into the Program. I consent to the collection, use, access and disclosure of my Personal Information, including health information, by the Program Administrator, Ferring and Ferring's agents, in accordance with the Patient Terms. I further consent to being contacted from time to time by the Program Administrator, Ferring and Ferring's agents and service providers in connection to the Program.

Signature: _____
Name of Patient or Legal Representative, if applicable (please print): _____ Date (DD/MMM/YYYY): _____

FIRMAGON®+ PATIENT SUPPORT PROGRAM ENROLMENT FORM

TERMS & CONDITIONS

PLEASE READ THE ENTIRE FORM CAREFULLY. If you have any questions, please ask the person who gave you this form to explain it to you.

The Firmagon®+ Patient Support Program, herein referred to as "**the Program**", is sponsored by Ferring Inc. ("**Ferring**") and administered by a third-party service provider, its affiliates, subcontractors, or other contractors as appointed by Ferring (the "**Program Administrator**"), Ferring has appointed Bayshore Specialty Rx Ltd. ("**Bayshore**") as the Program Administrator of the Program. The Program offers patient support services, such as reimbursement or financial assistance, educational resources, facilitation of access to treatment administration and specialty pharmacy delivery services, and treatment follow-up to enrolled patients who have been prescribed Firmagon®.

Ferring has the right to terminate or modify the Program, and any services offered through the Program at any time without prior notice to you. Ferring may appoint other Program Administrators to administer the Program from time to time. If at any time and for any reason, Ferring appoints a new Program Administrator to administer the Program, your Personal Information or Prescriber Information (as defined below) will be shared to such provider in order to continue your participation in the Program. You provide your express consent for Ferring to transfer your Personal Information and personal health information to any successor chosen by Ferring to administer the Program, and that such consent shall apply even if you are no longer active in the Program and/or deceased.

Please contact the Program's Privacy Officer at any time in order to update or access your Personal Information or Prescriber Information, modify or withdraw your consent (in part or in full), express a privacy-related concern, or inquire about the privacy practices of the Program. The Privacy Officer may be reached by email at: privacyofficer@bayshore.ca, by phone at: 1-800-668-9490 or in writing by mail to: 2101 Hadwen Rd., Mississauga, Ontario L5K 2L3.

PATIENT DISCLOSURE & CONSENT

Your personal information, including your name, date of birth, gender, address, contact information, financial information, health information (including your medical history, medical condition(s), information relating to your treatment, prescription information), health card number, and insurance information (collectively, "**Personal Information**"), that you, your healthcare provider(s), insurers or payors provide to the Program will be used for the purpose of administering and managing the Program. Your Personal Information will be used to determine your eligibility for participation in the services offered by the Program, for identity verification purposes, and for communicating and coordinating with you and with your healthcare provider(s), insurer(s) and payors on your behalf.

Ferring has a legal obligation to monitor product complaints and report safety information and adverse reactions to Health Canada and other health authorities. Personal Information provided to the Program may be reported to local or international health authorities, or monitored by Ferring, its agents and/or its service providers for safety-related data and product complaints in order to ensure compliance with legal reporting requirements. Ferring, its agents or its service providers may contact you, your prescribing physician or healthcare providers for additional information to fulfill its obligations.

Your health card number may be disclosed to other healthcare provider(s) involved in your treatment as required or used for accessing and/or integrating public health databases, including Electronic Health Records (EHRs) and Electronic Medical Records (EMRs), as allowed by applicable provincial laws for the healthcare provider(s)' review and/or documentation of your treatment, or for the purposes of analysis of treatment patterns, healthcare outcomes, and effectiveness of healthcare interventions as it relates to your treatment.

Your Personal Information may be combined with the information of others who participate in the Program in order to generate aggregated data that does not contain identifying information. De-identified and/or aggregated Personal Information may be used by Ferring and its service providers to improve and/or refine the Program; to design and/or implement other patient programs; and for research purposes [e.g. identification of patterns, prediction of health trends, assessment of treatment safety and/or effectiveness, patient-reported outcomes and clinical decision-making]. De-identified and/or aggregated Personal Information may also be used in collaboration with healthcare providers, or regulatory bodies, such as supporting regulatory submissions and health policy decisions in compliance with health authorities (e.g., Health Canada). In addition, your Personal Information may be used or disclosed to other third parties when permitted or required by applicable laws, court orders, or government regulations.

Personal Information collected through the Program may be stored outside of Canada, including the United States and Europe, where local laws may require disclosure of personal information to governmental authorities under circumstances that are different than those that apply in Canada. Industry-standard technical and organizational measures will be used to protect the security of Personal Information that is collected. Your Personal Information will be retained for as long as is needed to fulfill the purposes for which it was collected and in accordance with applicable legislation, regulations, guidelines and privacy policies related to the Program. Bayshore's Privacy Policy is available at https://bayshorespecialtyrx.ca/privacy-policy/, and Ferring's Pharmacovigilance Privacy Notice is available at https://www.ferring.ca/en/global/pharmacovigilance-privacy-notice/.

YOUR PARTICIPATION IN THE PROGRAM IS VOLUNTARY. You may withdraw (in part or in full) or modify your consent at any time by sending a signed request to the Program Administrator by fax at 1-866-963-6488 or by email at firmagonplus@bayshore.ca. Withdrawing or modifying your consent does not prevent you from accessing the treatment prescribed by your healthcare provider. Withdrawing your consent will result in the termination of your enrolment in the Program, which means that you will not be able to receive Program services, including but not limited to financial assistance and reimbursement assistance as of the date of withdrawal. Withdrawal or modification of consent will have no retroactive effect, and any Personal Information already provided to the Program will be retained for the purposes and uses outlined in this form. By withdrawing your consent, no new data about you will be collected.

PHYSICIAN DISCLOSURE & CONSENT

By enrolling the above-named patient (the "Patient") into the Program, you represent that (i) you are the treating physician of the Patient; (ii) you have met with the Patient and discussed the Program with them; (iii) the Patient understands the Program; (iv) the Patient is interested in enrolling in the Program; (v) you will be responsible for all necessary medical and clinical counselling required for the treatment of Firmagon®, whether delivered by yourself or another delegated healthcare provider; (vi) you understand that the Program cannot provide any medical advice or recommendations to your patients, including upon Patient request, and will direct your Patient back to your care under such circumstances; (vii) the Patient's condition is within the indications listed in the current Canadian Firmagon® Product Monograph and that the prescribed treatment and dosage is appropriate based on your clinical judgement; (viii) the Patient understands and consents to you providing their personal information, including their name, date of birth, gender, address, contact information, financial information, health information (including their medical history, medical condition(s), information relating to their treatment, prescription information), health card number, and insurance information for the purpose of enrolment in the Program; (ix) the Patient consents to being contacted by the Program for the purpose of enrolling in the Program; (x) a new prescription will be required should the Patient re-enrol or meet the criteria to continue in the Program; and (xi) there is no direct personal benefit (e.g. monetary payment) to you for your or the Patient's participation in the Program.

The Program will collect personal information, namely your name, contact information, clinic name, license number, specialty, clinic address(es) and contact information (collectively, "**Prescriber Information**"), whether directly or indirectly (e.g. IQVIA data, provincial college websites or other public domains). You consent to the collection of your Prescriber Information, and the use and disclosure of your Prescriber Information for the purposes of administering the Program; monitoring and evaluating the Program; complying with regulatory requirements, including reporting obligations relating to adverse events and product complaints; and any collection, use and disclosure as permitted or required by law. You further consent to the use and disclosure of your name, license number and contact information to appropriate payors for the purpose of reimbursement assistance for the Patient, where applicable. You agree to the disclosure of your license number and contact information to Ferring for reporting purposes including, but not limited to, research, development and sales data. You also agree to the disclosure of appropriate clinical documentation to controllers and auditors contracted by Ferring for audit purposes.

Your de-identified Prescriber Information may be used by the Program Administrator, Ferring and Ferring's agents to improve and/or refine the Program; and/or to design and/or implement other patient programs.

You consent to the Program Administrator, Ferring and Ferring's agents contacting you if they require further information regarding product complaints and adverse events related to the Patient, the Program, Firmagon®, for the purposes of administering the Program, sharing relevant information collected about the Patient (e.g. adverse events), and inquiring about your experience with the Program so that services may be enhanced.

Your Prescriber Information will be retained for as long as is needed to fulfill the purposes for which it was collected and in accordance with applicable legislation, regulations, guidelines and privacy policies related to the Program. Bayshore's Privacy Policy is available at https://bayshorespecialtyrx.ca/privacy-policy/, and Ferring's Pharmacovigilance Privacy Notice is available at https://www.ferring.ca/en/global/pharmacovigilance-privacy-notice/.

You understand that you may revoke this consent at any time by sending a signed request to Bayshore at 2101 Hadwen Rd., Mississauga, Ontario L5K 2L3, or by fax to 1-866-963-6488, or by email to firmagonplus@bayshore.ca. You understand that should your Patient continue in the Program, this consent extends to the duration of your Patient's involvement in the Program.

FERRING PHARMACEUTICALS
www.ferring.ca

CA-FN-2500002

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