Patient Support Program

PfizerFlex

ENROLMENT FORM

Pr Abrilada® adalimumab

call **1-855-935-FLEX (3539)**
fax **1-833-958-FLEX (3539)**
email **abrilada@pfizerflex.com**

Download contact information

PATIENT INFORMATION (to be completed by the patient)

Name: _____

Address: _____

Tel. (Home): _____ **Tel.** (Cell): _____

Leave messages: ☐ Yes ☐ No **Send text** (SMS): ☐ Yes ☐ No

Best time to be contacted: ☐ AM ☐ PM ☐ Night

Email: _____

Date of birth: DD/MM/YYYY

PHYSICIAN INFORMATION (to be completed by the physician)

Physician name: _____

License no.: _____

Address: _____

Tel. (Office): _____

Fax (Office): _____

Office contact name: _____

Email: _____

MEDICAL INFORMATION (to be completed by the physician)

Chest X-ray required? ☐ No ☐ Yes Result: _____

TB test required? ☐ No ☐ Yes Result: _____

If TB test positive, is patient receiving anti-TB treatment? ☐ No ☐ Yes, to be completed on: DD/MM/YYYY

Has the patient ever suffered a severe allergic reaction? ☐ No ☐ Yes

Allergies: _____

Additional information: _____

INJECTION SUPPORT

I require PfizerFlex to provide injection training and/or services: ☐ Yes ☐ No Comments: _____

PRESCRIPTION INFORMATION (to be completed by the physician)

Check a format, diagnosis, and dosage

ABRILADA® will be supplied in boxes of two units, in one of the following formats:

☐ Prefilled syringe ☐ Prefilled pen

Provincial formulary code (if applicable): _____

☐ **Rheumatoid Arthritis**
40 mg SC every other week

☐ **Polyarticular Juvenile Idiopathic Arthritis**
☐ **10 to <30 kg*:** 20 mg SC every other week
☐ **≥30 kg:** 40 mg SC every other week

☐ **Psoriatic Arthritis**
40 mg SC every other week

☐ **Ankylosing Spondylitis**
40 mg SC every other week

☐ **Crohn's Disease**
☐ **Adults:** Week 0=160 mg SC, Week 2=80 mg SC, then 40 mg SC every other week starting Week 4
☐ **13–17 years ≥40 kg:** Week 0=160 mg SC, Week 2=80 mg SC, then 20 mg SC every other week starting Week 4

☐ **Ulcerative Colitis**
☐ **Adults:** Week 0=160 mg SC, Week 2 =80 mg SC, then 40 mg SC every other week starting Week 4
☐ **5–17 years <40 kg:** ***Induction dose*** (first 4 weeks): Week 0=80 mg SC, Week 2=40 mg SC
Maintenance dose (after 4 weeks):
☐ 20 mg SC every week
☐ 40 mg SC every other week
☐ **5–17 years ≥40 kg:** ***Induction dose*** (first 4 weeks): Week 0=160 mg SC, Week 2=80 mg SC
Maintenance dose (after 4 weeks):
☐ 40 mg SC every week
☐ 80 mg SC every other week

☐ **Plaque Psoriasis**
Week 0=80 mg SC, then 40 mg SC every other week starting Week 1

☐ **Uveitis**
☐ **Adults:** Week 0=80 mg SC, then 40 mg SC every other week starting Week 1
☐ **Pediatric <30 kg:** 20 mg SC every other week
☐ **Pediatric ≥30 kg:** 40 mg SC every other week

☐ **Hidradenitis Suppurativa**
☐ **Adults:** Week 0=160 mg SC, Week 2=80 mg SC, then 40 mg SC every week starting Week 4
☐ **12–17 years ≥30 kg:** Week 0=80 mg SC, then 40 mg SC every other week starting Week 1

☐ **Other dosing:** _____ **Duration of treatment:** ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: _____

* A dose of 10 mg every other week can be considered for patients weighing 10 to <15 kg.
Please consult the Product Monograph for important information relating to dosing, administration, adverse reactions, and drug interactions.

PHYSICIAN SIGNATURE (to be completed by the physician)

Do you accept that Pfizer Canada's Drug Safety Unit contact you regarding information shared on this form or any accompanying document? ☐ Yes ☐ No

Notes: _____

☐ **I have read, understand, and agree to the physician consent statement on the reverse.**

SIGN HERE: _____ Date†: DD/MM/YYYY

† Effective date. Order(s) expires one year from the date of signature. Prescriber certification: I certify that this prescription is an original prescription and this pharmacy is the only receiver. The original will not be reused.

PATIENT SIGNATURE (to be completed by the patient)

SIGN HERE: _____ Date: DD/MM/YYYY

☐ I have read and understood the Patient Consent text printed on the back of this form and agree to the collection, use, and disclosure of my Health Information in accordance with these terms.

☐ I consent to the receipt of electronic communications containing information and updates relating to the **PfizerFlex Program**. The **Administrators** (the service providers elected by Pfizer to administer the **PfizerFlex Program** offerings) are seeking your consent on behalf of Pfizer Canada ULC, the sponsor of the Program. You can withdraw your consent to receive electronic communications by following the instructions provided in the electronic communication. You can contact the Program Administrators at any time by calling 1-855-935-FLEX (3539) or at: **PfizerFlex Program**, P.O. Box 34586, 3131 Côte-Vertu Blvd., Ville Saint-Laurent, QC H4R 2P4.

Fax completed form to **1-833-958-FLEX (3539)**

PATIENT CONSENT

Agreement to Disclose Personal Information – PfizerFlex Program

Special Instructions: This consent form may contain words or phrases that are new to you. If any part of this form is not clear to you, please ask the person who gave you this form to explain it to you. Words that are written in **bold type** are explained on the bottom of this section.

We are asking for your permission to collect, to use, and to share your **Personal Information**.* The patient assistance program for ABRILADA called **PfizerFlex**† ("Program") is a free Program offered to all patients who have been prescribed ABRILADA. The Program can help you in a number of ways. Sharing your Personal Information as described on this form will help us figure out which Program services and materials are best for you.

For you to take part in the Program and for us to carry out the Program activities for you, you agree to:

- Allow your **Healthcare Providers**‡, the Administrators (the service providers elected by Pfizer to administer the program offerings) and the **PfizerFlex Program Personnel**§ ("Program Personnel") to collect, use, share with each other, and store your Personal Information. These people are described at the bottom of this form.
- Allow the Program Personnel to use the Personal Information that you provide to contact you, and to collect other Personal Information from you that is needed or related to the administration of the Program. For example, this may include asking for your feedback on the quality of the services offered by the Program or any other related services, or your progress while taking the medication ABRILADA, and may include limited market research, such as surveys on your experiences, so that Pfizer may better understand and improve its products and programs. Program Personnel may leave messages for you at the phone number you give them, if you have checked the *Leave messages* box on this enrolment form.
- Allow Pfizer Canada (the company that sells ABRILADA) and its affiliates ("Pfizer") to collect your Personal Information and information on any unwanted drug effects ("adverse drug events" or side effects) that you may have while taking ABRILADA or other medications made by Pfizer. Commonly, Pfizer and Health Canada ask for this information to track the safety record of these medications. The information collected from you and others taking these medications allows them to better understand how these medications can affect the patients who take them. This information may be provided to Health Canada or to another regulatory agency to report any adverse drug events, or as otherwise may be required by law. Pfizer may also contact your Healthcare Providers if they need more information.
- Allow Pfizer, or a service provider hired by Pfizer, to have access to your Personal Information in order to audit the Program or provide recommendations on how to improve the Program. For example, Pfizer or its service provider may review documents that contain your Personal Information, or monitor phone conversations between you and Program Personnel for quality control purposes. Any service provider will be required to only use your Personal Information for purposes relating to the audit/Program administration, and will not disclose your Personal Information to third parties.
- Allow Pfizer to collect, share, and publish anonymized statistical data with healthcare providers and third parties for reimbursement, publication, or commercial purposes.
- The Administrator and Program Personnel can administer the prescribed ABRILADA medication to me during a pre-scheduled specialty clinic appointment. Such treatment shall include administration of prescribed pre-medication and management of injection related reactions or emergencies during the injection treatment appointment.

By giving your consent, you understand that:

- You agree to receive Program services, support, and materials suitable for your needs.
- The Program Personnel are not allowed to collect, use, share, or store your Personal Information for anything other than the activities described in this consent form. They cannot share any of your Personal Information with anyone other than your Healthcare Providers, unless the **Health Information*** that identifies you is removed. For example, your name, address, and any personal identifiers must be removed if any of your Health Information is shared with anyone who is not your Healthcare Provider. Health Information which does not have your name, address, or personal identifiers could still be shared after you withdraw your consent.
- You may take back your consent at any time by calling the Administrators at 1-855-935-FLEX (3539) or sending a request with your signature to the Administrators by fax to 1-833-958-FLEX (3539). Your consent is needed to receive services from the PfizerFlex Program. If you decide to take back your consent, you will no longer be enrolled in the PfizerFlex Program. This means that you will not be able to receive any support services from the Program, and you may not be able to get financial assistance for ABRILADA if you are eligible.
- Except where prohibited by law, you may have a copy of your Personal Information. You can correct any mistakes and/or ask the Administrators any questions about the collection, use, sharing, and storage of your Personal Information. You may contact the Administrators by calling 1-855-935-FLEX (3539) or by faxing your request to 1-833-958-FLEX (3539).
- Any calls to or from the Administrators while providing services of the Program may be monitored or recorded for control of quality and to train their personnel.
- Your Personal Information may be collected, used, shared, and/or stored outside of your province or territory or country. The laws of those countries regarding privacy may be less strict than the laws of Canada and its provinces.
- Your Personal Information may also be disclosed and/or transferred to a third party in the event of a proposed or actual purchase, sale (including a liquidation, realization, foreclosure, or repossession), lease, amalgamation or any other type of acquisition, disposal, transfer, conveyance, or financing of all or any portion of Pfizer Canada or of any of the business or assets or shares of Pfizer Canada or a division thereof.
- Pfizer Canada has the right to modify or cancel the Program and the services offered by the Program at any time without prior notice to you.
- If at any time and for any reason Pfizer Canada appoints new Program Administrators, you will allow the transfer of your Personal Information by the Administrators or by Pfizer to the new Administrators in order to continue your participation in the Program.
- You will not seek to have the amount of support you receive by way of this program counted in any Government out-of-pocket expenses for prescription drugs.
- Unless your consent is withdrawn, your consent is valid for as long as you receive services from the Program and for a reasonable time thereafter.

* Your **Personal Information** includes your individual information (name, gender, address, phone number, date of birth, etc.), your financial information, and your **Health Information** (medical history, medical condition(s), information relating to your treatment, information relating to your health insurance, etc.).

† The **PfizerFlex Program** is sponsored by Pfizer Canada to help patients get access to ABRILADA, and to help them manage their treatment plan for the indications authorized for use by Health Canada.

‡ **Healthcare Providers** include all of your doctors, nurses, pharmacists or pharmacy support staff, private insurance company(s), public payer(s) and any other healthcare provider or payer that may possess the necessary information.

§ **PfizerFlex Program Personnel** include the employees and consultants of the Administrators, as well as any service providers that are engaged by the Administrators to manage or perform Program services and activities.

PHYSICIAN CONSENT

My signature acknowledges that:

- I am the prescribing physician of this patient;
- I have prescribed this patient ABRILADA for a Health Canada-authorized indication;
- Subject to the above-noted patient's consent and only to the extent of such patient's consent:
  - I consent to the **PfizerFlex Program Personnel**¶ contacting me with regard to the above-noted patient to assist it in administering the program, and without limitation with regard to patient reimbursement and patient care;
  - I consent to the Administrators (the service providers elected by Pfizer to administer the program offerings) receiving, collecting, storing, using, and disclosing any of my information that I provide in respect to the patient that is necessary to assist the patient in obtaining any services or assistance the patient has authorized and consented to;
  - I consent to Pfizer Canada (the company who sells ABRILADA) and its affiliates ("Pfizer") to contact me with regard to the above-noted patient if they require further information on adverse drug events pertaining to ABRILADA, or other medications manufactured by Pfizer;
  - I agree to allow the Administrators to provide this prescription to the pharmacy chosen by the above-named patient or another pharmacy (where applicable) to ensure the patient obtains access to the therapy I have prescribed;
  - I agree to allow the Administrators to contact me for any other information regarding the **PfizerFlex Program**** that would result in enhancing the delivery or the quality of services offered by this program to my patient.

¶ **PfizerFlex Program Personnel** include the employees and consultants of the Administrators elected by Pfizer to administer the Program.

** The **PfizerFlex Program** is sponsored by Pfizer Canada to help patients get access to ABRILADA, and to help them manage their treatment plan for the indications authorized for use by Health Canada.

For more information, please refer to the ABRILADA Product Monograph.
The Product Monograph is available upon request or it can be accessed at https://www.pfizer.ca/en/our-products/abrilada-adalimumab-injection.

Pr Abrilada® adalimumab

Patient Support Program
PfizerFlex
Experienced, Dedicated Team

Pfizer

MEMBER OF INNOVATIVE MEDICINES CANADA

REVIEWED BY PAAB

PP-ABD-CAN-0077-EN

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PfizerFlex

ENROLMENT FORM

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email **abrilada@pfizerflex.com**

Download contact information

PATIENT INFORMATION (to be completed by the patient)

Name: _____

Address: (No. & Street Name) _____

(City, Province) _____ (Postal Code)_____

Tel. (Home): _____ **Tel.** (Cell): _____

Leave messages: ☐ Yes ☐ No **Send text** (SMS): ☐ Yes ☐ No

Best time to be contacted: ☐ AM ☐ PM ☐ Night

Email: _____

Date of birth: DD/MM/YYYY **Health card number:** _____

PHYSICIAN INFORMATION (to be completed by the physician)

Physician name: _____

License no.: _____

Address: (No. & Street Name) _____

(City, Province) _____ (Postal Code)_____

Tel. (Office): _____

Fax (Office): _____

Office contact name: _____

Email: _____

MEDICAL INFORMATION (to be completed by the physician)

Chest X-ray required? ☐ No ☐ Yes Result: _____

TB test required? ☐ No ☐ Yes Result: _____

If TB test positive, is patient receiving anti-TB treatment? ☐ No ☐ Yes, to be completed on: DD/MM/YYYY

Has the patient ever suffered a severe allergic reaction? ☐ No ☐ Yes

Allergies: _____

Additional information: _____

INJECTION SUPPORT

I require PfizerFlex to provide injection training and/or services: ☐ No ☐ Yes

Comments: _____

PRESCRIPTION INFORMATION (to be completed by the physician)

Check a format, diagnosis and dosage

ABRILADA® will be supplied in boxes of two units, in one of the following formats:

☐ Prefilled syringe ☐ Prefilled pen

Provincial formulary code (if applicable): _____

☐ **Plaque Psoriasis**
- ☐ Week 0=80 mg SC, then 40 mg SC every other week starting Week 1

☐ **Psoriatic Arthritis**
- ☐ 40 mg SC every other week

☐ **Hidradenitis Suppurativa**
- ☐ Week 0=160 mg SC, Week 2=80 mg SC, then 40 mg SC every week starting Week 4

☐ **Adolescent Hidradenitis Suppurativa** (12–17 years ≥30 kg)
- ☐ Week 0=80 mg SC, then 40 mg SC every other week starting Week 1

☐ **Other dosing**: _____

Duration of treatment: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: _____

Please consult the Product Monograph for important information relating to dosing, administration, adverse reactions, and drug interactions.

PHYSICIAN SIGNATURE (to be completed by the physician)

Do you accept that Pfizer Canada's Drug Safety Unit contact you regarding information shared on this form or any accompanying document? ○ Yes ◉ No

Notes: _____

☐ **I have read, understand and agree to the physician consent statement on the reverse.**

SIGN HERE: _____ Date*: DD/MM/YYYY

* Effective date. Order(s) expires one year from the date of signature. Prescriber certification: I certify that this prescription is an original prescription and this pharmacy is the only receiver. The original will not be reused.

PATIENT SIGNATURE (to be completed by the patient)

SIGN HERE: _____ Date: DD/MM/YYYY

☐ I have read and understood the Patient Consent text printed on the back of this form and agree to the collection, use and disclosure of my Health Information in accordance with these terms.

☐ I consent to the receipt of electronic communications containing information and updates relating to the **PfizerFlex Program**. The **Administrators** (the service providers elected by Pfizer to administer the **PfizerFlex Program** offerings) are seeking your consent on behalf of Pfizer Canada ULC, the sponsor of the Program. You can withdraw your consent to receive electronic communications by following the instructions provided in the electronic communication. You can contact the Program Administrators at any time by calling 1-855-935-FLEX (3539) or at: **PfizerFlex Program**, P.O. Box 34586, 3131 Côte-Vertu, Ville Saint-Laurent, QC H4R 2P4.

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PATIENT CONSENT

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For you to take part in the Program and for us to carry out the Program activities for you, you agree to:

- Allow your **Healthcare Providers**‡, the Administrators (the service providers elected by Pfizer to administer the program offerings) and the **PfizerFlex Program Personnel**§ ("Program Personnel") to collect, use, share with each other, and store your Personal Information. These people are described at the bottom of this form.
- Allow the Program Personnel to use the Personal Information that you provide to contact you, and to collect other Personal Information from you that is needed or related to the administration of the Program. For example, this may include asking for your feedback on the quality of the services offered by the Program or any other related services, or your progress while taking the medication ABRILADA, and may include limited market research, such as surveys on your experiences, so that Pfizer may better understand and improve its products and programs. Program Personnel may leave messages for you at the phone number you give them, if you have checked the *leave messages* box on this enrolment form.
- Allow Pfizer Canada (the company that sells ABRILADA) and its affiliates ("Pfizer") to collect your Personal Information and information on any unwanted drug effects ("adverse drug events" or side effects) that you may have while taking ABRILADA or other medications made by Pfizer. Commonly, Pfizer and Health Canada ask for this information to track the safety record of these medications. The information collected from you and others taking these medications allows them to better understand how these medications can affect the patients who take them. This information may be provided to Health Canada or to another regulatory agency to report any adverse drug events, or as otherwise may be required by law. Pfizer may also contact your Healthcare Providers if they need more information.
- Allow Pfizer, or a service provider hired by Pfizer, to have access to your Personal Information in order to audit the Program or provide recommendations on how to improve the Program. For example, Pfizer or its service provider may review documents that contain your Personal Information, or monitor phone conversations between you and Program Personnel for quality control purposes. Any service provider will be required to only use your Personal Information for purposes relating to the audit/Program administration, and will not disclose your Personal Information to third parties.
- Allow Pfizer to collect, share, and publish anonymized statistical data with healthcare providers and third parties for reimbursement, publication, or commercial purposes.
- The Administrator and Program Personnel can administer the prescribed ABRILADA medication to me during a pre-scheduled specialty clinic appointment. Such treatment shall include administration of prescribed pre-medication and management of infusion related reactions or emergencies during the infusion treatment appointment.

By giving your consent, you understand that:

- You agree to receive Program services, support, and materials suitable for your needs.
- The Program Personnel are not allowed to collect, use, share, or store your Personal Information for anything other than the activities described in this consent form. They cannot share any of your Personal Information with anyone other than your Healthcare Providers, unless the **Health Information*** that identifies you is removed. For example, your name, address, and any personal identifiers must be removed if any of your Health Information is shared with anyone who is not your Healthcare Provider. Health Information which does not have your name, address, or personal identifiers could still be shared after you withdraw your consent.
- You may take back your consent at any time by calling the Administrators at 1-855-935-FLEX (3539) or sending a request with your signature to the Administrators by fax to 1-833-958-FLEX. Your consent is needed to receive services from the PfizerFlex Program. If you decide to take back your consent, you will no longer be enrolled in the PfizerFlex Program. This means that you will not be able to receive any support services from the Program, and you may not be able to get financial assistance for ABRILADA if you are eligible.
- Except where prohibited by law, you may have a copy of your Personal Information. You can correct any mistakes and/or ask the Administrators any questions about the collection, use, sharing and storage of your Personal Information. You may contact the Administrators by calling 1-855-935-FLEX (3539) or by faxing your request to 1-833-958-FLEX (3539).
- Any calls to or from the Administrators while providing services of the Program may be monitored or recorded for control of quality and to train their personnel.
- Your Personal Information may be collected, used, shared, and/or stored outside of your province or territory or country. The laws of those countries regarding privacy may be less strict than the laws of Canada and its provinces.
- Your Personal Information may also be disclosed and/or transferred to a third party in the event of a proposed or actual purchase, sale (including a liquidation, realization, foreclosure, or repossession), lease, amalgamation or any other type of acquisition, disposal, transfer, conveyance, or financing of all or any portion of Pfizer Canada or of any of the business or assets or shares of Pfizer Canada or a division thereof.
- Pfizer Canada has the right to modify or cancel the Program and the services offered by the Program at any time without prior notice to you.
- If at any time and for any reason Pfizer Canada appoints new Program Administrators, you will allow the transfer of your Personal Information by the Administrators or by Pfizer to the new Administrators in order to continue your participation in the Program.
- You will not seek to have the amount of support you receive by way of this program counted in any Government out-of-pocket expenses for prescription drugs.
- Unless your consent is withdrawn, your consent is valid for as long as you receive services from the Program and for a reasonable time thereafter.

* Your **Personal Information** includes your individual information (name, gender, address, phone number, date of birth, etc.), your financial information, and your **Health Information** (medical history, medical condition(s), information relating to your treatment, information relating to your health insurance, etc.).

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‡ **Healthcare Providers** include all of your doctors, nurses, pharmacists or pharmacy support staff, private insurance company(s), public payer(s), and any other healthcare provider or payer that may possess the necessary information.

§ **PfizerFlex Program Personnel** include the employees and consultants of the Administrators, as well as any service providers that are engaged by the Administrators to manage or perform Program services and activities.

PHYSICIAN CONSENT

My signature acknowledges that:

- I am the prescribing physician of this patient;
- I have prescribed this patient ABRILADA for a Health Canada-authorized indication;
- Subject to the above-noted patient's consent and only to the extent of such patient's consent:
  - I consent to the **PfizerFlex Program Personnel**¶ contacting me with regard to the above-noted patient to assist it in administering the program, and without limitation with regard to patient reimbursement and patient care;
  - I consent to the Administrators (the service providers elected by Pfizer to administer the program offerings) receiving, collecting, storing, using, and disclosing any of my information that I provide in respect to the patient that is necessary to assist the patient in obtaining any services or assistance the patient has authorized and consented to;
  - I consent to Pfizer Canada (the company who sells ABRILADA) and its affiliates ("Pfizer") to contact me with regard to the above-noted patient if they require further information on adverse drug events pertaining to ABRILADA, or other medications manufactured by Pfizer;
  - I agree to allow the Administrators to provide this prescription to the pharmacy chosen by the above-named patient or another pharmacy (where applicable) to ensure the patient obtains access to the therapy I have prescribed;
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For more information, please refer to the ABRILADA Product Monograph.
The Product Monograph is available upon request or it can be accessed at https://www.pfizer.ca/en/our-products/abrilada-adalimumab-injection.

Pr Abrilada® adalimumab

Patient Support Program PfizerFlex

Pfizer

MEMBER OF INNOVATIVE MEDICINES CANADA

REVIEWED BY PAAB

PP-ABD-CAN-0089