PrMONOFERRIC™ (Ferric Derisomaltose) INFUSION
PRESCRIPTION, INFUSION ORDERS, AND CONSENT FORM
PLEASE SEND THE COMPLETED FORM TO THE APPROPRIATE NUMBER LISTED BELOW:

FAX: 1-833-262-1642 OR **E-mail** : A2C@supportprogram.com

SECTION 1: PATIENT INFORMATION Please complete or attach patient label *required fields

First Name*:	Last Name*:	Sex: ☐ M ☐ F	
Date of Birth (DOB) (dd/mm/yyyy)*:	Health Card Number:		
Address:	City, Province:	Postal Code:	
Phone Number*: Leave voice message: ☐ Yes ☐ No	Alternate Phone Number: Leave Voice Message: ☐ Yes ☐ No	Best time to contact: ☐ Morning (8 am - 12 pm) ☐ Afternoon (12 pm - 5 pm) ☐ Evening (5 pm - 8 pm)	
Alternate Contact (First & Last Name):		Relationship to Patient:	
Allergies (specify):	Notes:		

SECTION 2: PRESCRIBING PHYSICIAN INFORMATION *required fields

Prescribing Physician Name (First & Last)*:	License Number:	
Address:	City, Province:	Postal Code:
Phone Number*:	Fax Number*:	
E-mail:	Would you like to receive a post infusion report: ☐ Yes ☐ No	

SECTION 3: PHYSICIAN Rx & INFUSION INFORMATION The information below will serve as a valid prescription if signed and dated by the Prescribing Physician

PrMONOFERRIC™ (Ferric Derisomaltose)

Dose: _____

☐ Doses up to 1000 mg must be administered by IV over a minimum of 20 minutes

☐ Doses exceeding 1000 mg must be administered by IV over a minimum of 30 minutes

** If the cumulative iron dose exceeds 20 mg iron/kg body weight, the dose must be split in two administrations with an interval of at least one week. It is recommended whenever possible to give 20 mg iron/kg body weight in the first administration. Dependent on clinical judgement the second administration could await follow-up laboratory tests.*

Infusion to be provided at:

☐ INVIVA Infusion Clinic - A2C will arrange appointment (separate infusion fee will apply)

☐ Hospital Outpatient Clinic - Prescriber to arrange infusion appointment

Comments:

Prescribing Physician's Certification: I certify that the prescription is an original prescription and that pharmacy is the only receiver. The original will not be reused.

Prescribing Physician's Signature:_____ **Date (yyyy/mmm/dd):** _____

SEE PATIENT CONSENT ON THE NEXT PAGE

A2C Immunology Patient Care Navigation Program
Patient Participation & Consent

A. OVERVIEW OF THE PROGRAM

The A2C Immunology Patient Care Navigation Program (the "**Program**") is a patient-centered program offered and administered by McKesson Specialty Health, a division of McKesson Canada Corporation and/or its affiliates ("**McKesson**"). This Program is aimed at improving health outcomes and disease management for patients diagnosed with an autoimmune disease (the "**Condition**"). Your access to the Program services may vary based on your Condition and as directed by your physician. These services may include (1) assistance with navigating the reimbursement and financial support process such as investigating your insurance coverage and assisting in registering for public coverage where available. (2) coordinating fulfilment of your pre-treatment services, such as vaccinations, bloodwork, pre-biologic testing, treatment reminders, adherence and pharmacy counselling. (3) coordinating the provision of educational resources and materials to help you better manage your Condition and treatment. (4) coordinating the medication administration, training, and delivery (the "**Services**"). Where a Patient Support Program exists for the medication you have been prescribed, delivery of the Services mentioned above will be coordinated with the Patient Support Program where possible.

Your participation in the Program is voluntary. If you choose not to participate, neither your medical treatment nor your insurance coverage eligibility will be impacted. However, if you do not participate, you cannot receive assistance or Services from the Program. The Program is not intended to provide medical advice, medical diagnoses, or treatment recommendations. You agree to seek the advice of your physician or other qualified health care professional if you have health concerns, and not to disregard professional medical advice based on information obtained from the Program. McKesson reserves its right to modify or terminate the Program at any time without prior notice.

B. CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL AND PERSONAL HEALTH INFORMATION

I acknowledge that I have read and understand the information below and consent to the collection, use, and disclosure of my personal information, including personal health information, by McKesson, its employees, agents, and its service providers for the purposes of administering the Program. Furthermore, I acknowledge that I am responsible for selecting the pharmacy, clinic, or facility that will conduct the dispensing, delivery, and/or the administration of my medication (if necessary). If I do not have a preferred pharmacy, clinic, or facility, the Program will help me locate such resource in my community based on my treating physician's recommendations. I understand that these are third parties and that McKesson cannot be held responsible for the information or services that these third parties may offer me.

Information such as my name, gender, date of birth, contact information, emergency contact information, medical history (including relevant medical diagnosis, information on current medication, medical allergies, pharmacy information, and insurance/financial information (collectively "**Personal Information**") is collected to communicate with me and to provide me with the Program's Services as explained herein. Depending on the Services I use in connection with the Program, McKesson may also, on a confidential basis, collect my Personal Information from, and share it with, my healthcare providers (such as my physician and pharmacy), insurance providers (public or private), its agents, as well as other service providers (e.g., information technology providers), including available manufacturer Patient Support Programs, as necessary to administer the Program. I authorize sharing of my Personal Information to and from the parties mentioned above. Personal identifiers may be removed from my Personal Information, or my Personal Information may be combined with the information of others who participate in the Program to create aggregated data that does not contain any identifying information ("**Aggregated Data**"). McKesson and its service providers may store or process my Personal Information outside of Canada (including the United States), where local laws may require the disclosure of personal information under circumstances that differ to those that apply in Canada. Also, my Personal Information may be used or disclosed to third parties when permitted or required by applicable laws, court orders, or government regulations.

My Personal Information will be retained only for as long as is needed to fulfill the purposes for which it was collected and to comply with applicable laws. Industry standard safeguards will be used to protect the security of the Personal Information that is collected. I may contact the Program at any time to update or access my Personal Information, modify, or withdraw my consent (in part or in full), express a privacy-related concern, or inquire about the privacy practices of the Program. I may request access to, or correction of, my Personal Information by contacting A2C Immunology Program in writing at A2C@supportprogram.com or phone 1-855-310-5104. You may also need to contact your respective Patient Support Program to complete this process, as indicated on the Patient Support Program's enrolment form. Also, any additional information about McKesson's privacy policies and practices is available at https://www.mckesson.ca/web/mckesson-canada-extranet/privacy .

I understand that withdrawing my consent will result in the termination of my participation in the Program and its Services. The withdrawal of my consent will mean that no new personal information will be collected, however, I understand that the file containing my Personal Information will be maintained for monitoring and legal purposes, and that Aggregated Data will continue to be used as described above.

To be completed by the patient.

By signing below, I acknowledge that I am being enrolled into the A2C Immunology Patient Care Navigation Program and will be receiving its affiliated services. I have read and understood the program consent language and I consent to have my Information shared as described within.

Consent to contact by way of electronic communications

☑ By checking this box, I accept that representatives of the Program, acting on its behalf, may communicate with me via electronic means such as email and text message, for the purposes of providing me with information and updates relating to the Program. I understand that communicating via electronic means may not be the most secure means of communication and as such, sensitive health information will not be included in any electronic means of communication with me. At any time, I will have the opportunity to opt-out from such electronic communications by contacting the Program at 1-855-310-5104 or by email at A2C@supportprogram.com

Consent to use and disclose additional information

Subject to your election at the end of this Section, you grant to McKesson the right and permission to use and disclose to its affiliates (as defined under the Ontario Corporation Act) or other service providers, as needed for various purposes, including but not limited to help McKesson assess, audit and improve patient assistance programs and how it provides services to patients, additional Personal Information about yourself in aggregated (combined with other data) or de-identified form (personally identifiable information removed), such as information regarding your health outcome, your demographics and the name and contact information of your healthcare providers such as your treating physician (the "**Additional Information**"). Additional Information in aggregated or de-identified form may also be used to perform activities such as, including but not limited to research purposes, data assessment and data analytics for the purposes of, amongst other initiatives, optimizing service offerings to patients and other third parties as well as the commercialization of such offerings. Our third-party service providers are contractually obliged to strict data protection and security requirements. Only relevant personnel will have access to your Additional Information.

☑ By checking this box, I authorize McKesson to use and disclose my Personal Information solely as described above.

Patient or Legal Guardian Signature: _____ Date: _____

Patient Name: _____ A2C Patient ID#: _____

Legal Guardian Name: _____ CONSENT PROVIDED BY LEGAL GUARDIAN ☐