cares patient support program | stronger together

Pr Doptelet (avatrombopag) tablets

THE SOBI CARES PATIENT SUPPORT PROGRAM: ENROLMENT AND CONSENT FORM FOR CANADIAN PATIENTS TREATED WITH DOPTELET®

Sobi Cares Patient Support Program – Contact Information

Phone: 1-833-697-0049
Fax: 1-833-852-0062
Email: sobi_cares@innomar-strategies.com

Please sign and fax or email the completed form and required documentation to the Sobi Cares Patient Support Program ("Program"). Asterisk indicates required field or section.
If you have any questions, please contact the Program Monday–Friday, 8 am–8 pm ET.

PATIENT INFORMATION AND CONSENT

First name* (Print legibly)_____ Middle initial _____ Last name* _____
DOB* (DD/MM/YYYY) _____ Gender _____ Language preference: ☐ English ☐ French
Address* (No PO Box allowed) _____ Apt. number _____
City* _____ Province* _____ Postal code* _____ Email _____
Phone* _____ Consent is given to the Program to: ☐ Text ☐ Leave detailed voice message
Alternate phone _____ Consent is given to the Program to: ☐ Text ☐ Leave detailed voice message
Provincial HC number _____ Caregiver name _____ Phone _____ Email _____

☐ I am providing consent for myself and have read, understand, and agree to the "Patient Consent" found on the reverse of this form. **OR** ☐ Physician has obtained patient's verbal consent from the "Patient Consent."

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOUR PERSONAL INFORMATION WILL BE COLLECTED, USED, AND/OR DISCLOSED FOR THE PURPOSES OUTLINED IN THE "PATIENT CONSENT" SECTION ON THE REVERSE OF THIS FORM.

Signature of patient _____ Signature of legal representative (if applicable) _____
Legal representative (print name) _____ Relationship of legal representative to patient _____ Date (DD/MM/YYYY) _____

PRESCRIBER INFORMATION

First name* _____ Last name* _____ Specialty* _____
License #* _____ Office/Clinic/Institution name* _____
Address* _____ City* _____ Province* _____ Postal code* _____
Phone* _____ Ext. _____ Fax* _____ Email _____
Primary office contact: Name* _____
Phone* _____ Fax* _____ Email _____ Preferred contact: ☐ Phone ☐ Fax ☐ Email

PRESCRIPTION INFORMATION

Please check one of the following to indicate purpose of prescription:
☐ Chronic immune thrombocytopenia (ITP)
☐ Other

PrDOPTELET® (avatrombopag) is indicated for the treatment of thrombocytopenia in adult patients with chronic ITP who have had an insufficient response to a previous treatment.

Prior treatment:

DOPTELET (avatrombopag) 20-MG TABLETS
DIN: 02542706

SELECT ONE OPTION
☐ 10 CT
☐ 15 CT
☐ 30 CT

Directions:

☐ NKDA ☐ Drug/food allergies: _____
Patient platelet count *(not required)*: _____ ☐ Refill(s) _____

Send prescription to: ☐ Sobi Cares Program pharmacy ☐ I authorize the Program to send the prescription to the patient's pharmacy of choice on my behalf
Patient's preferred pharmacy (please indicate): _____

PRESCRIBER CONSENT AND AUTHORIZATION

The prescriber is to comply with his/her province-specific prescription requirements such as e-prescribing, province-specific prescription form, fax language, etc. Non-compliance with province-specific requirements could result in outreach to the prescriber.

By signing below, I confirm: A) I am the prescribing physician; B) This is an original prescription for Doptelet; C) I agree to be contacted by Sobi Canada, Inc. ("Sobi"), its affiliates and partners in connection with this patient's care and/or enrolment in the Sobi Cares Patient Support Program; D) I have discussed the Sobi Cares Patient Support Program with the patient and have either had the patient sign the consent form or I have obtained verbal consent from the patient to share the patient's information in this form with the Program, and as needed to provide the Program's services; E) I authorize Sobi as my designated agent for the purposes of forwarding this prescription, by fax or other mode of delivery, to the appropriately designated pharmacy determined either by the patient's benefit plan or the above-designated pharmacy; F) I agree to the disclosure of my license number and coordinates to Sobi for reporting purposes including, but not limited to, research, development, and sales data; G) This request has been prepared exclusively by me or my office; H) I will notify Sobi immediately if I become aware that this patient's insurance or income status has changed; I) The information I have provided is accurate and complete to the best of my knowledge.

Prescriber signature* (no stamps) Date* (DD/MM/YYYY)

Consult the Product Monograph at sobi.ca/Doptelet_PM_EN for contraindications, warnings, precautions, adverse reactions, interactions, dosing and conditions of clinical use. The Product Monograph is also available through Sobi's medical department at 1-866-773-5274.

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PATIENT CONSENT

Sobi Cares Patient Support Program ("Program") is sponsored by Sobi Canada, Inc. ("Sobi") and currently managed by Innomar Strategies, an independent third party contracted by Sobi to administer the Program ("Program Administrator"). The Program includes services such as reimbursement investigation and assistance to patients prescribed Doptelet ("Support Services"). Sobi reserves the right to terminate or change the Program at any time without prior notice or delay, including by moving the Program to a new Program Administrator.

I have been given the opportunity to discuss this Program with my physician and I understand that participation in the Program is voluntary. I hereby consent to the Program collecting, using, disclosing and storing my "Personal Information" (as defined below) to determine my eligibility for and in connection with my participation in the Program and to provide me with Support Services as outlined herein.

I understand the Program may collect information from, and share information with, my healthcare providers and their staff, including my physician(s) and pharmacist(s) (collectively, "Healthcare Providers"), insurance providers (private or public) as well as other service providers retained for the Program or for other purposes as permitted or required by law. I accept that my information, including Personal Information, may be used by Sobi or its agents for reasons related to improving, monitoring and auditing its programs, for commercial or market research purposes (for example, conducting surveys of my experience with the Program), and as otherwise required or permitted by law. The information collected and shared may include information about my insurance coverage, medical condition and other personal and health information, as well as all information included on this Patient Enrolment and Consent Form (collectively, "Personal Information").

I authorize my physician to provide the Program Administrator with this completed Patient Enrolment and Consent Form and other Personal Information as may be necessary to provide Program services. I agree I may be contacted by the Program Administrator, Healthcare Providers or others for information required for my enrolment in and the administration of the Program, by email, phone or otherwise using the contact information provided.

Use and disclosure of your Personal Information

The Program Administrator (and its authorized representatives and agents) may collect, use and/or share your Personal Information to:

- Administer the Program;
- Provide you with the Support Services;
- Determine your eligibility for the Program and Support Services;
- Personalize the Program and Support Services to your specific circumstances;
- Provide you with materials relating to your medication, treatment, and the Program;
- Contact you to inform you of changes in the Program and Support Services;
- Obtain your feedback on the Program and Support Services;
- Evaluate and report patient outcome data associated with the administration of Doptelet;
- Perform internal evaluation and assessments of the Program and Support Services; and
- Undertake safety monitoring, reporting, and auditing and responding to enquiries or issues in relation to medication, or as otherwise may be required by law.

I understand that my 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 ("Aggregated Data"). Aggregated Data may be used by Sobi and its service providers to improve and/or refine the Program, to design and implement other patient programs and for research purposes including the identification of trends such as product utilization, adherence or outcomes. Aggregated Data may also be used to help Sobi and its service providers to help develop, evaluate, or improve the Program, our products, services, materials and treatment, and to conduct research, including future scientific research and publications.

I understand that the Program Administrator is responsible for the collection, use and disclosure of Personal Information collected for the purposes of the Program. I understand Sobi may receive de-identified data from this Program, but will not receive my Personal Information, except, if required, certain information (e.g., initials, date of birth and gender, but not name) for adverse event reporting purposes to enable Sobi to follow up with my Healthcare Providers. This is necessary for Sobi to maintain the most up-to-date records as to the safety of its products. Adverse event information may need to be reported to health authorities in and outside of Canada.

I understand the file containing my Personal Information will be maintained at the offices of the Program Administrator, who will collect, use, disclose and protect my Personal Information as described above and otherwise in accordance with its privacy policy. Authorized employees, agents and mandataries of the Program Administrator will have access to my Personal Information as necessary to administer the Program. Personal Information collected in connection with the Program may be stored or processed outside of Canada. I understand that where Personal Information is stored or processed outside of Canada, it may be subject to the laws of foreign jurisdictions. For information about the Program Administrator policies and practices regarding its service providers, or for a copy of its privacy policy, I can submit a written request to Privacy Officer, Innomar Strategies, 3470 Superior Court, Oakville, ON, L6L 0C4.

I understand that any financial assistance provided to me as a result of my enrolment in the Program may be reportable income to public or private payers or government agencies. I understand that I am solely responsible for such reporting as well as for ensuring compliance with accepting any such financial assistance.

I have the right to opt out of this consent at any time by contacting the Program at **1-833-697-0049** or **sobi_cares@innomar-strategies.com**; however, any withdrawal of consent shall not have retroactive effect. I may request access to, or correction of, my Personal Information, or withdraw my consent at any time by contacting the Program Administrator in writing at the address above. I understand that withdrawing my consent will result in the termination of my enrolment in the Program.

sobi

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