Patient Enrolment, Rx & Consent Form

PLEASE FAX TO YOUR JANSSEN BIOADVANCE® COORDINATOR UPON COMPLETION

Janssen BioAdvance® Coordinator:	Tel.:	Fax:

PATIENT INFORMATION

Gender: ☐ M ☐ F

Patient Name:	
Address:	
Language preference: ☐ English ☐ French ☐ Other	
Tel. (Home):	Tel. (Other):
Can leave a message at this phone number: ☐ YES ☐ NO	
Email:	
Date of Birth:	Health Card #:

PHYSICIAN INFORMATION

Physician Name:	
Other Office Contact:	
Office Address:	
Email:	
Tel. (Office):	Fax (Office):

PRESCRIBING PHYSICIAN SECTION‡

Please ☑ and complete the required information.

Indication: ☐ Plaque Psoriasis ☐ Psoriatic Arthritis	Patient Weight:

☐ **ADULT** (18 years old and above) **PRESCRIPTION**

☐ STELARA® (ustekinumab) **45 mg** subcutaneous injection

☐ STELARA® (ustekinumab) **90 mg** subcutaneous injection

☐ STELARA® (ustekinumab) **45 mg** subcutaneous injection **x 2**

☐ **PEDIATRIC** (6-17 years old) **PRESCRIPTION**‡ (plaque psoriasis)

☐ STELARA® (ustekinumab) **45 mg** subcutaneous injection

☐ STELARA® (ustekinumab) **90 mg** subcutaneous injection

☐ STELARA® (ustekinumab) **0.75 mg/kg** (45 mg / 0.5 ml vial)

DOSE

INITIAL weeks: ☐ 0 ☐ 4 ☐ 16 ☐ 28

AND / OR

MAINTENANCE: Q weeks: ☐ Weeks ☐ Repeats

OR ☐ 52 weeks

Other Directives / Notes:

REIMBURSEMENT

PSORIASIS ASSESSMENT DETAILS
(please complete if necessary)

BSA %:	PASI:	DLQI:

☐ Face ☐ Hands ☐ Feet ☐ Genitals

TUBERCULOSIS EVALUATION

☐ Not Required

☐ Negative Result Date:

☐ Pending

☐ Positive Result Date:

☐ Ontario, Psoriasis only: Patient qualifies for coverage under LU code 419

PREVIOUS THERAPY

	Reason for discontinuation:	Start/stop dates:
☐ Methotrexate	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Acitretin	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Cyclosporine	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Topicals	☐ Intolerance ☐ Contraindication ☐ Failure	
☐ Phototherapy	☐ Intolerance ☐ Contraindication ☐ Failure ☐ Not Available	
☐ Other	☐ Intolerance ☐ Contraindication ☐ Failure	

PHYSICIAN

‡ Effective date. Order(s) expire 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.

Physician Signature:	College License #:	Date‡:

PATIENT

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 personal information in accordance with these terms.

Patient Signature:	Date:

CP-170596E

PATIENT CONSENT

I agree to permit my healthcare provider(s), including physician(s) or nurse(s), to disclose my personal information to the BioAdvance® Coordinator assigned to managing my patient file, or his/her replacement (where applicable) (the "BAC") in order to facilitate my enrolment in the BioAdvance® Program and facilitate the obtaining of my first STELARA® prescription, and I agree that the BAC can contact me for such purposes. Personal information may include my name, address, date of birth, phone numbers and any other personal information, including my personal health information, such as my diagnosis and the information included on my prescription or on this Patient Enrolment, Rx & Consent Form (the "Consent Form").

My personal information will not be used or disclosed by the BAC for any purpose other than those described above unless information that identifies me directly is first removed or as is permitted or required by law. In addition, once I have been contacted by the BAC, if I elect to benefit from the services provided by the BAC, I will be required to sign another consent form with respect to the collection, use and disclosure of my personal information by the BAC.

I understand that:

- I do not have to sign this Consent Form, but if I do not, my healthcare provider(s) will not be able to disclose my personal information to the BAC and I will not be able to benefit from the services provided by the BAC (unless I contact the BAC directly myself);
- The medical treatment provided by my healthcare provider(s) will not be impacted by whether I sign this consent form or not;
- I may revoke (take back) this authorization at any time by mailing or faxing signed letter(s) of revocation to my healthcare provider(s), but if I do so, I will be unable to benefit from the services provided by the BAC;
- Revoking this authorization will prohibit disclosure of my health information by my healthcare provider(s) after the date my letter of revocation is received and processed, but will not affect the use or disclosure of information already received by the BAC;
- I am entitled to a copy of this Consent Form;
- If I want to access my patient file maintained by the BAC and/or make changes or corrections to it, I may do so by written request to the currently active BAC.

‡ **In pediatric patients, it is recommended that STELARA® be administered by a healthcare provider.***

* STELARA® (ustekinumab) Product Monograph, Janssen Inc. Available at: http://www.janssen.com/canada/

Please see product monograph for full prescribing information for STELARA®.
For more information, please contact Janssen Inc. Medical Information at 1-800-567-3331.